

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# 59-026454

## FILED VS JUL 24 1959

STATE FILE NUMBER

 Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2-6412**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>5 hours</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>City Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3728 Ohio Avenue</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Hattie</b> Middle <b>Clementine</b> Last <b>Brown</b>				4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>1959</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>12/5/1879</b>		9. AGE (last birthday) <b>79</b> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook (retired)</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>		11. BIRTHPLACE (City and state or country) <b>Greenup, Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>Phillip Coleman</b>			13b. MOTHER'S MAIDEN NAME <b>Emily Garrol</b>			14. NAME OF HUSBAND OR WIFE <b>George Brown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>468-01-5459</b>		17. INFORMANT Address <b>Mrs. Treva Menzel, 3728 Ohio Ave. St. Louis</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio sclerotic Heart Disease</b> DUE TO (b) <b>Arterio sclerosis</b> DUE TO (c) <b>420.0</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____		-Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ <b>6:20 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Do not sign in ink) <b>Paul J. Simon</b>				22b. ADDRESS <b>1300 Clark</b>		22c. DATE SIGNED <b>7/7/59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>7/8/1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>			
24. FUNERAL DIRECTOR <b>HOFFMEISTER COLONIAL MORTUARY</b>			ADDRESS <b>6464 CHIPPEWA ST. ST. LOUIS, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>JUL 7 '59</b>		26. REGISTRAR'S SIGNATURE <b>Harold Smith, M.D.</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Bill C. Drannon

Licensed Embalmer No. 4764

P. O. Address St Louis,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.