

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 13 1959

59-033433

Registration District No. 510 Primary Registration District No. 3058 Registrar's No. 222 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Charles			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY ST. CHARLES			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Charles		Length of stay in 1b UNKNOWN	c. CITY OR TOWN St. Charles		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1019 Olive St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ernest Middle Brice Last Brice			4. DATE OF DEATH Month Sept. Day 16 Year 1959			
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH 4-24-02	9. AGE (last birthday) 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Various	11. BIRTHPLACE (City and state or country) Portland Missouri		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Neomi Brice		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW 2		16. SOCIAL SECURITY NO. 500-03-6090	17. INFORMANT Address Wm. Ernest Brice 3847 Ashland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Infarction left cerebral Hemisphere					36 hrs	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Thomboses basilas Artery					36 hrs	
DUE TO (c) Generalized Arteriosclerosis					10 yrs	
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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 May 1959 to Sept. 1959 and last saw ^{XX} him alive on Sept. 16, 1959 Death occurred at 5:00 P. m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <i>Wm H Progenie</i> (Degree or title) <i>MD</i>			22b. ADDRESS St. Charles, Mo		22c. DATE SIGNED Sept 18, 1959	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-21-59	23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION (City, town, or county) Jefferson Eks. Mo.		
24. FUNERAL DIRECTOR Glenn & Walker 4319 Delmar Blvd			25. DATE RECD. BY LOCAL REG. INT. SEPT 28 59 CENT. OCT. 6 - 59	26. REGISTRAR'S SIGNATURE <i>Marcella Wilson</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NS OCT 14 1950

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 *Lloyd M. Brown*

Licensed Embalmer No. 4523

P. O. Address 4251 Washington

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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.