

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033621

FILED VS SEP 30 1959

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2-8638**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri</b>		Length of stay in 1b <b>3 Weeks</b>	c. CITY OR TOWN <b>East St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Infirmary</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>121 North 22nd Street</b>
a. STATE <b>Illinois</b>		b. COUNTY <b>St. Clair</b>	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
First	Middle	Last	Month	Day	Year	
<b>WILLIE LEOLA BROWN</b>			<b>September 17, 1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/20/1916</b>	9. AGE (last birthday) <b>43</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>Nelton, Mississippi</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
13a. FATHER'S NAME <b>William LaGrone</b>		13b. MOTHER'S MAIDEN NAME <b>Lottie Gardner</b>	
14. NAME OF HUSBAND OR WIFE <b>Learn 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>Unknown</b>	17. INFORMANT <b>Learn Brown, Husband, 121 No. 22nd St.</b>	Address <b>E. St. L., Ill.</b>
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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)	<b>None</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<b>Delayed Hippocampus</b>	
DUE TO (b)		
DUE TO (c)		

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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 **7/27/59** to **9/17/59** and last saw her alive on **9/12/59**  
Death occurred at **12 noon 9/17/59** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Edgar F. Warden M.D.</b>	22b. ADDRESS <b>938 N L NOT SET</b>	22c. DATE SIGNED <b>9/18/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/21/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Garden</b>	23d. LOCATION (City, town, or county) (State) <b>Stokey Township, Ill.</b>
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24. FUNERAL DIRECTOR <b>Marion's Office</b>	ADDRESS <b>2114 Missouri Ave. E. St. Louis, Ill.</b>	25. DATE RECD BY LOCAL REG. <b>SEP 19 1959</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith M.D.</b>
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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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Frank Proloff

Licensed Embalmer No. 4356

P. O. Address St Louis, Mo

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.