

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

59-041616

FILED VS DEC 7 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's **210983** STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 7 1/2 mo.	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3331 Laclede		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle Henry Last Brown			4. DATE OF DEATH Month 11 Day 18 Year 59		
5. SEX Male	6. COLOR OR RACE Col.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-20-84	9. AGE (last birthday) 75	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) Unknown		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) S. Car.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Sam Brown		13b. MOTHER'S MAIDEN NAME Addie Jones		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	17. INFORMANT Chronic Hospital Records 5600 Arsenal Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage into the Abdominal cavity caused by ruptured liver on the lower surface; Fractured ribs, left side; Chronic Atrophic Myocarditis and Coronary Sclerosis; suffered at Chronic Hosp.; EXACT DATE AND MANNER OF SAME COULD NOT BE					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) DETERMINED.					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"/> OPEN VERDICT		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 4-6-59 to 11-18-59 and last saw her/him alive on 11-18-59 Death occurred at 10:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Paul J. Simon</i>		(Degree or title) Deputy Chron		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 11/27/59		(State)			
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation	23b. DATE 11-28-59	23c. NAME OF CEMETERY OR CREMATORY City Crematory		23d. LOCATION (City, town, or county) St. Louis, Missouri	
24. FUNERAL DIRECTOR Frank O'Donnell		ADDRESS 5600 Arsenal St.		25. DATE RECD. BY LOCAL REG. NOV 27 1959	
26. REGISTRAR'S SIGNATURE <i>Paul Smith M.D.</i> mgs					

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.

NOT EMBALMED **CREMATED BY CITY.**

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.