

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003813

FILED VS FEB 10 1960

2 1045

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 40 years | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer Phillips Hosp. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| | | d. STREET ADDRESS (If outside, give location) 4343 Cottage Avenue | |
| | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|---|----------------------------------|---|---|---|---|
| 3. NAME OF DECEASED (Type or print) First Middle Last EDWARD MIDDLEBROOKS | | | 4. DATE OF DEATH Month Day Year January 26, 1960 | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 12/26/92 | 9. AGE (last birthday) 67 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Wheel Foundry | 11. BIRTHPLACE (City and state or country) Okalona, Miss. | 12. CITIZEN OF WHAT COUNTRY U. S. A. | |
| 13a. FATHER'S NAME Willis Middlebrooks | | 13b. MOTHER'S MAIDEN NAME Thenia Carr | | 14. NAME OF HUSBAND OR WIFE Nellie Middlebrooks | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War I | | 16. SOCIAL SECURITY NO. 316-03-4497 | 17. INFORMANT Address Nellie Middlebrooks 4343 Cottage | | |

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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) Asystolia | | | 1-5 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Cirrhosis | | several years |
| | DUE TO (c) Kidney disease | | " " |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) hypertensive cardiovascular disease | | | 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 |

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|---|---|--|--------------|
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Month, Day, Year a.m. p.m. | | | |
| 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 1-19-60 to 1-26-60 and last saw him alive on 1-26-60 Death occurred at 8:45 PM 1-26-60 m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |

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|--|-------------------------------|--|---|------------------------------------|
| 22a. SIGNATURE (Degree of title) J. W. Hoard MD / Pathologist MD | | 22b. ADDRESS Carson Lix-Kinloch Mo | | 22c. DATE SIGNED 1-28-60 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 2/1/60 | 23c. NAME OF CEMETERY OR CREMATORY National Cemetery | 23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo. | |
| 24. FUNERAL DIRECTOR Charles J. Gates | ADDRESS 4107 Finney | 25. DATE RECD. BY LOCAL REG. JAN 29 1960 | 26. REGISTRAR'S SIGNATURE Carl Smith, M.D. | |

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 _____

Guyton Swan

Licensed Embalmer No. **4580**

P. O. Address **4107 Finney Av**

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.