

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-007994

FILED VS. MAR 8 1960

Primary Registration District No. _____ Registrar's **2 2345**

STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY	<i>ST. Louis, Mo.</i>	a. STATE	<i>Mo</i> b. COUNTY <i>Franklin</i>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN	<i>St Louis Mo</i>	c. CITY OR TOWN	<i>St. Clair, Mo</i>
Length of stay in 1b	<i>3 months</i>	Inside Limits	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION	<i>Cardinal Glennan Hosp</i>	d. STREET ADDRESS	(If outside, give location) <i>—</i>
Inside Limits	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Reside on Farm	Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First	Middle	Last	Month	Day Year
<i>LORI ANN BROWN.</i>			<i>Feb</i>	<i>28 1960.</i>
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)
<i>Female</i>	<i>White</i>		<i>Nov 19 1938</i>	<i>3 9</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
<i>none</i>		<i>none</i>	<i>Washington, Mo</i>	<i>U.S.A.</i>
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE	
<i>Carl D Brown</i>		<i>Carol Sue Anderson</i>	<i>none</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address	
			<i>Carl D. Brown St. Clair, Mo</i>	

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)	<i>Congestive heart failure</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Congenital heart disease</i> DUE TO (c) <i>Ventricular Septal defect</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days.
<i>Pneumonia</i>		<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	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 <i>2-10-60</i> to <i>2-28-60</i> and last saw her him alive on <i>2-28-60</i> Death occurred at <i>9 25 p m</i> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title)		22b. ADDRESS	22c. DATE SIGNED
<i>V. S. Hillman, M.D.</i>		<i>1825 S. G rand St. Louis Mo</i>	<i>2-29-60</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>March 2 1960</i>	<i>Green Mound Cem</i>	<i>St. Clair, Mo.</i>
24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE	
<i>Sherrill W. Mitchell, St. Clair, Mo.</i>	<i>FEB 29 1960</i>	<i>Loard Smith, M.D.</i>	

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

Shemond E. Kitchel

Licensed Embalmer No. 387

P. O. Address St. Clair

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.