

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-016649

FILED VS. APR 22 1960

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 3934** STATE FILE NUMBER

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|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Illinois</b> b. COUNTY <b>Perry</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>       |  | c. CITY OR TOWN <b>Pinckneyville</b>   |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b> |  | d. STREET ADDRESS (If outside, give location) <b>1 West North St.</b>  |  |

|  |                                  |   |  |                                     |  |  |
|--|----------------------------------|---|--|-------------------------------------|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <b>CLYDE</b> Middle <b>ALAN</b> Last <b>BROWN</b> |                                  |   | 4. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>8</b> Year <b>1960</b> |                                     |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12/9/1890</b>                                 | 9. AGE (last birthday)<br><b>69</b> | IF UNDER 1 YEAR<br>Months _____ Days _____ | IF UNDER 24 HR<br>Hours _____ Min. _____ |

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Auto Dealer</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Automotive</b> |  | 11. BIRTHPLACE (City and state or country)<br><b>Perry County, Illinois</b> |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>       |  |
| 13a. FATHER'S NAME<br><b>David Brown</b>  |  |  | 13b. MOTHER'S MAIDEN NAME<br><b>Margaret McClure</b> |   |  | 14. NAME OF HUSBAND OR WIFE<br><b>Carrie Brown</b> |  |

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|--|--|---|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No.</b> |  | 16. SOCIAL SECURITY NO.<br><b>344-05-7957</b> |  | 17. INFORMANT<br><b>Carrie Brown, Pinckneyville, Illinois.</b> |  |
|--|--|---|--|--|--|

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: |  |  | INTERVAL BETWEEN ONSET AND DEATH |  |  |
| IMMEDIATE CAUSE (a) <b>ACUTE LEFT HEART FAILURE WITH PULMONARY EDEMA</b>                                 |  |  | <b>40 MINUTES</b>                |  |  |
| DUE TO (b) <b>GENERALIZED ARTERIOSCLEROTIC VASCULAR DISEASE</b>  |  |  | <b>12 YEARS</b>                  |  |  |
| DUE TO (c) <b>450.0</b>  |  |  |                                  |  |  |

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|--|--|--|--|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>CHRONIC BRAIN SYNDROME</b> |  |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
|--|--|--|--|--|--|

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| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.<br>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 **SEPT. 6, 1932** to **APRIL 8, 1960** and last saw her/him alive on **APRIL 8, 1960**  
Death occurred at **1:45 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

|  |  |  |  |                                   |  |
|--|--|--|--|-----------------------------------|--|
| 22a. SIGNATURE<br><i>C. D. McMillan, M.D.</i> (Degree or title) <b>M. D.</b> |  | 22b. ADDRESS<br><b>BARNES HOSPITAL</b> |  | 22c. DATE SIGNED<br><b>4/8/60</b> |  |
|--|--|--|--|-----------------------------------|--|

|   |  |                             |  |   |  |   |  |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b> |  | 23b. DATE<br><b>4-10-60</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Cemetery</b> |  | 23d. LOCATION (City, town, or county) (State)<br><b>Perry County, Illinois.</b> |  |
|---|--|-----------------------------|--|---|--|---|--|

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|---|--|---|--|--|--|
| 24. FUNERAL DIRECTOR<br><b>Albert H. Hoppe Inc., 4700 Washington, Blvd.</b> |  | 25. DATE RECD. BY LOCAL REG.<br><b>APR 9 1960</b> |  | 26. REGISTRAR'S SIGNATURE<br><i>Carl Smith, M.D.</i> |  |
|---|--|---|--|--|--|

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

COPYING MACHINE

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 John J. Harris Licensed Embalmer No. 11,08 P. O. Address St. Louis

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.