

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-021223**

**FILED VS. MAY 25 1960**

**318**

Primary Registration District No. **1003**

Registrar's No. **4991**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		Length of stay in 1b <b>1 1/2 yr</b>		c. CITY OR TOWN <i>St Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MASONIC HOME HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5351 DELMAR AVE.</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>MARGARET</b> First <b>B</b> Middle <b>LONG</b> Last				4. DATE OF DEATH <b>MAY</b> Month <b>8</b> Day <b>1960</b> Year			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>7-15-1900</b>	9. AGE (last birthday) <b>59</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <b>Practical nurse</b>		11. BIRTHPLACE (City and state or country) <b>Canton Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>JAMES FINLEY BRODRITH</b>			13b. MOTHER'S MAIDEN NAME <b>SARAH ALICE SUMMERS</b>			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)		16. SOCIAL SECURITY NO. <b>*</b>		17. INFORMANT Address <i>Masonic Home Records</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u><i>Gastrointestinal hemorrhage (cause unknown)</i></u> DUE TO (b) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <u><i>Cushing-like Syndrome</i></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u><i>277x</i></u> 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						INTERVAL BETWEEN ONSET AND DEATH <u><i>10 min</i></u> <u><i>20 yrs.</i></u>	
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 _____ 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 <u><i>I-1-57</i></u> , to <u><i>5-8-60</i></u> and last saw her/him alive on <u><i>5-7-60</i></u> Death occurred at <u><i>9-45 AM.</i></u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Harold E. Walters M.D.</i>			22b. ADDRESS <i>3720 Washington St. hwy. Mo.</i>			22c. DATE SIGNED <i>5-8-60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>MAY 31 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Anatomical Board</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>			
24. FUNERAL DIRECTOR ADDRESS <i>Rowland Aker Mortuary Service</i> <i>4104 Manchester</i> <i>ST LOUIS, MO</i>			25. DATE RECD. BY LOCAL REG. <i>MAY 12 1960</i>		26. REGISTRAR'S SIGNATURE <i>Loan Smith. M.D.</i> <i>ms</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 \_\_\_\_\_

02-1-2

02-8-2

02-1-2 Licensed Embalmer No. \_\_\_\_\_  
02-1-2 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.