

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-030008

FILED VS SEP 8 1960 77

Registration District No. _____ Primary Registration District No. 3016 Registrar's No. 302

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Cole</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jefferson City</u> Length of stay in 1b <u>3 yr. 4 mo.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Prison Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pemiscot</u> c. CITY OR TOWN <u>Steele</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS <u>Daughters 4454 St. L. Ave. St. Louis</u> (If outside, give location) <u>St. Louis, Mo.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>—</u> Last <u>Brown</u>			4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1/28/86</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown (Army) worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (City and state or country) <u>Preston Lake, Ark.</u>		12. CITIZEN OF WHAT COUNTRY <u>United States</u>	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>nephew Paul Jones 217 W. St. Alysathelle</u> <u>Mo. State Penitentiary</u>			
18. CAUSE OF DEATH (Enter only one cause per part. Death was caused by: PART I. IMMEDIATE CAUSE (a) <u>Ac. congestive failure</u> DUE TO (b) <u>Arteriosclerotic cardiovascular system</u> DUE TO (c) <u>Bronchial Asthma not known</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 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 type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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>4/30/59</u> to <u>8/24/60</u> and last saw her/him alive on <u>8/24/60</u> Death occurred at <u>6:45 pm</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>[Signature]</u>			22b. ADDRESS <u>Prison Hospital Jefferson City, Mo.</u>		22c. DATE SIGNED <u>8/25/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>8/29/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Kirksville College of Art</u>		23d. LOCATION (City, town, or county) (State) <u>Kirksville Mo</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Thorpe J Gordon, Jefferson City, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>30 August 1960</u>		26. REGISTRAR'S SIGNATURE <u>R.P. Davis M.D. Richter, Dep.</u>			

DOCUMENT

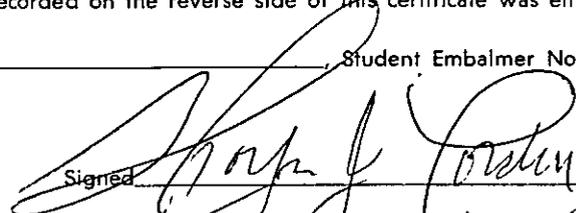
MEDICAL CERTIFICATION

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  _____

Licensed Embalmer No. 1786
P. O. Address Jeff City, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.