

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 28yrs	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Res. 6228 Fauquier		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6228 Fauquier
3. NAME OF DECEASED (Type or print) James Roy Brashear		4. DATE OF DEATH Aug 7, 1960	

5. SEX M	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/26/1879	9. AGE (last birthday) 82yrs	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) Father Pres Brashear Freight Lines		10b. KIND OF BUSINESS OR INDUSTRY Freight Lines		11. BIRTHPLACE (City and state or country) Stephensport, Ky	12. CITIZEN OF WHAT COUNTRY USA	

13a. FATHER'S NAME Roy Brashear	13b. MOTHER'S MAIDEN NAME Hawkins	14. NAME OF HUSBAND OR WIFE Elizabeth B Brashear
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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) No None	16. SOCIAL SECURITY NO. 494-07-9656	17. INFORMANT Mr. Roy A Brashear 2947 Devondale Pl.
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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 3 years
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Dis.		
DUE TO (b) General arteriosclerosis		?
DUE TO (c) 420.0		

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	
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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.)
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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 _____
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21. I attended the deceased from **July 1955** to **Aug 7 '60** and last saw him alive on **July 27 1960**
 Death occurred at **6 p m** on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) James B Grant M.D.	22b. ADDRESS 1147 Taylor Ave	22c. DATE SIGNED 8-8-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug 10, 1960	23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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24. FUNERAL DIRECTOR Alexander & Sons 6175 Delmar	25. DATE RECD. BY LOCAL REG. AUG 8 1960	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 17 1960

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 James E. McCullough

Licensed Embalmer No. 2966

P. O. Address 6170 8th

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.