

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 17 1960 318

318

Primary Registration District No. 1003

Registrar's No. 7786

7786-60-031950

STATE FILE NUMBER

INDEXED

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,		c. CITY OR TOWN St. Louis,	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hosp.		d. STREET ADDRESS (If outside, give location) 2137 Maury Ave.	

3. NAME OF DECEASED (Type or print) First ROBERT Middle Last BROWN, SR.			4. DATE OF DEATH Month Aug. Day 5th Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-27-1885	9. AGE (last birthday) 75	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman-Driver		10b. KIND OF BUSINESS OR INDUSTRY Chapman Ice Cream Co.		11. BIRTHPLACE (City and state or country) Scotland (Nat)	
13a. FATHER'S NAME Robert Brown		13b. MOTHER'S MAIDEN NAME Margaret Unknown		14. NAME OF HUSBAND OR WIFE Ella Brown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 489-10-2145	17. INFORMANT Ella Brown- 2137 Maury Ave.
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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: IMMEDIATE CAUSE (a) Respiratory Death.		INTERVAL BETWEEN ONSET AND DEATH 1 year.
DUE TO (b) CHRONIC MYELOGELOUS LEUKEMIA ABOUT		
DUE TO (c) OR MYELOFIBROSIS		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 299X			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown		
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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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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 **7-16-60** to **8-5-60** and last saw her/him alive on **8-5-60**
Death occurred at **1:45 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Arthur W. Lull M.D. (Degree or title)	22b. ADDRESS Jewish Hospital	22c. DATE SIGNED 8-5-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Aug. 8, 1960	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	23d. LOCATION (City, town, or county) St. Louis County, Mo.
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24. FUNERAL DIRECTOR Kriegshauser-4228 S.Kingshighway Blvd.	25. DATE RECD. BY LOCAL REG. AUG 6 1960	26. REGISTRAR'S SIGNATURE Roal Smith, M.D.
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DOCUMENT

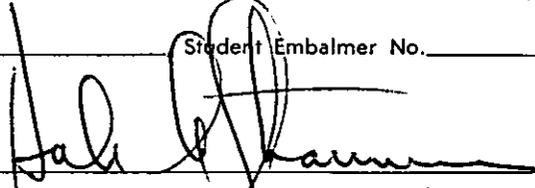
MEDICAL CERTIFICATION

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. 453

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.