

FILED VS AUG 2 2 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7721 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Missouri</u>		Length of stay in 1b <u>2 Weeks</u>	c. CITY OR TOWN <u>East St. Louis</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Infirmary</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>12 North 10th St.</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>BIRDIE LEE MILTON</u>			4. DATE OF DEATH Month Day Year <u>August 1, 1960</u>		
--	--	--	---	--	--

5. SEX <u>Female</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>1/4/20</u>	9. AGE (last birthday) <u>40</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
-------------------------	----------------------------------	---	-----------------------------------	-------------------------------------	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Brinkley, Arkansas</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
---	--	---	--

13a. FATHER'S NAME <u>WALTER BROWN</u>	13b. MOTHER'S MAIDEN NAME <u>FANNIE WILLIAMS</u>	14. NAME OF HUSBAND OR WIFE <u>STERLING MILTON</u>
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT Address <u>Fannie McCoo, 12 No. 10th Street</u>
---	---	--

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>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 hrs</u>
DUE TO (b) _____		
DUE TO (c) _____		

*ok. Cause of death is cerebral hemorrhage. Dept. of Health*

331x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None</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
--	---

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.) <u>None</u>
---	---	---

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 checked="" 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>May 16, 1960</u> to <u>Aug 1, 1960</u> and last saw her/him alive on <u>May 31, 1960</u> Death occurred at <u>8:30</u> P. m. on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <u>Dr. Joseph Howard</u> (Degree or title)	22b. ADDRESS <u>5593 CARSON Road St. Louis</u>	22c. DATE SIGNED <u>AUG 4 1960</u>
--	---	---------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/5/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Booker Washington</u>	23d. LOCATION (City, town, or county) (State) <u>Centerville Township, Ill.</u>
--	----------------------------	--	--

24. FUNERAL DIRECTOR <u>Marion's Office</u>	ADDRESS <u>2114 Missouri E. St. Louis, Ill.</u>	25. DATE RECD. BY LOCAL REG. <u>AUG 4 1960</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</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 Frank Prokoff

Licensed Embalmer No. 4356

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.