

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis		Length of stay in 1b	c. CITY OR TOWN Saint Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5255 Enright
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First MOSE Middle BROOKS Last			4. DATE OF DEATH Month October Day 19 Year 1960		
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/3/82	9. AGE (last birthday) 77	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Fireman		10b. KIND OF BUSINESS OR INDUSTRY City Waterworks	11. BIRTHPLACE (City and state or country) St. Louis Co., Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Daniel Brooks		13b. MOTHER'S MAIDEN NAME Lucy Ball		14. NAME OF HUSBAND OR WIFE Rosie Brooks	
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. Unknown	17. INFORMANT Address Jennetta Mozee, 5255 Enright		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) hemorrhagic shock		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b)		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (not related to the disease condition given in PART I (a)) Support in fall from 3rd floor		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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (If signature of injury in PART I or PART II of line 18) Support in fall from 3rd floor	
20c. TIME OF INJURY Hour a.m. p.m. 10 1960	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> Home		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		20f. CITY, TOWN, OR LOCATION St Louis Mo	STATE
21. I attended the deceased from 825 P.		and last saw her him alive on	
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) Joseph M. Quinn Deputy Registrar		22b. ADDRESS 1300 Clark	22c. DATE SIGNED 10-24-60
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/24/60	23c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery	23d. LOCATION (City, town, or county) (State) Chesterfield, Missouri
24. FUNERAL DIRECTOR ADDRESS Charles J. Gates, 4107 Finney		25. DATE RECD. BY LOCAL REG. OCT 22 1960	26. REGISTRAR'S SIGNATURE Roan Smith, M.D.

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 _____, Student Embalmer No. _____, or by _____, Student Embalmer No. _____, working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Lawrence B Woods

Licensed Embalmer No. 4341

P. O. Address 4107 Finney

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.