MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-007084
STATE FILE NUMBER

AMENDED ✓

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 385

FILED VS MAR 2 1961

1. PLACE OF DEATH
a. COUNTY ST LOUIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ~~Kinloch~~ CLAYTON
Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) County Hosp. D.O.A.
Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE ILL. b. COUNTY
c. CITY OR TOWN Mulberry Grove
Inside Limits Yes ☐ No ☑
d. STREET ADDRESS (If outside, give location) RT.2 Box 157
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Loretta Middle Last Brown
4. DATE OF DEATH Month 2- Day 4 Year -61

5. SEX F
6. COLOR OR RACE Negro
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH 12-18-07
9. AGE (last birthday) 53
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) Housewife
10b. KIND OF BUSINESS OR INDUSTRY ------
11. BIRTHPLACE (City and state or country) Missouri
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME UNKNOWN
13b. MOTHER'S MAIDEN NAME UNKNOWN
14. NAME OF HUSBAND OR WIFE UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT J. W. Stewart Address RT.2 Box157

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Unknown Natural Causes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Diabetes

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 ____, to ____ and last saw her/him alive on ____
Death occurred at 11A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John C. Murphy M.D. (Degree or title) John C. Murphy MD Asst. Health Commissioner
22b. ADDRESS 801 S. Brentwood Clayton, Mo.
22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 2-10-61
23c. NAME OF CEMETERY OR CREMATORY Washington Park
23d. LOCATION (City, town, or county) (State) Berkerley, MO.

24. FUNERAL DIRECTOR E.B. Koonce ADDRESS 1221 North Grand
25. DATE RECD. BY LOCAL REG. 2-7-61
26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Melvin Blankenhorn

Licensed Embalmer No. 3962

P. O. Address 1221 N. Gran

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.