

ISSUOR DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-81-014968  
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3774

AMENDED

FILED APR 27 1961

DATE AMENDED

INSTEAD OF THIS RECORD TAKE AS FOLLOWS

SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO</b>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY		c. CITY OR TOWN <b>ST. LOUIS,</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1.</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3029 THOMAS.</b>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>QUINN</b> Middle <b>HODNEY</b> Last <b>BROOKS</b>						4. DATE OF DEATH <b>APRIL 8, 1961</b> Month Day Year					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>4/6/61</b>		9. AGE (last birthday)		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>					
13a. FATHER'S NAME <b>NED BROOKS</b>				13b. MOTHER'S MAIDEN NAME <b>CATHRYN L. YOUNG</b>				14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>n none</b>		17. INFORMANT Address <b>ST. LOUIS CITY HOSP. #1.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congenital stelectosis</b>										INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b)			DUE TO (c)			<b>762.0'</b>		
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
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.)							
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			
21. I attended the deceased from <b>4/6/61</b> to <b>4/8/61</b> and last saw her/him alive on <b>4/8/61</b>				Death occurred at <b>3p</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Good J. Oulley M.D.</i>						22b. ADDRESS <b>1515 LAFAYETTE AVE</b>			22c. DATE SIGNED <b>4/10/61</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>APR 29 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>		23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>		23e. (State)			
24. FUNERAL DIRECTOR <i>Rowland - Owen 4104 Manchester</i>				ADDRESS		25. DATE RECD. BY LOCAL REG. <b>APR 20 1961</b>		26. REGISTRAR'S SIGNATURE <i>Good Smith, M.D.</i>			

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

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.