

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3537

STATE FILE NUMBER

**FILED APR 25 1961**

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 2 days	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair		c. CITY OR TOWN East St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Infirmary				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2212 Missouri Ave.			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MIDDLE Last ROBERT BROWN					4. DATE OF DEATH Month Day Year April 10, 1961					
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/17/1902	9. AGE (last birthday) 58	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) Chauffeur			10b. KIND OF BUSINESS OR INDUSTRY Private Family		11. BIRTHPLACE (City and state or country) Perry County, Ala.		12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME David Brown			13b. MOTHER'S MAIDEN NAME Addie Lockett			14. NAME OF HUSBAND OR WIFE Madeline 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.		17. INFORMANT Address Madeline Brown-2212 Missouri Av.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Basophilic Carcinoma</i> DUE TO (b) <i>Malnutrition &amp; Dehydration</i> DUE TO (c) <i>162.1</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH <i>6 mo</i> <i>1 wk</i>	
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 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.)						
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 <i>3/20/58</i> to <i>4/6/61</i> and last saw her/him alive on <i>4/6/61</i> . Death occurred at <i>9:30 p.m.</i> m on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <i>Chas. Smith M.D.</i>					22b. ADDRESS <i>401 Octy</i>			22c. DATE SIGNED <i>4/10/61</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4/13/61	23c. NAME OF CEMETERY OR CREMATORY Booker Washington		23d. LOCATION (City, town, or county) East St. Louis, Illinois		(State)			
24. FUNERAL DIRECTOR ADDRESS Marshall Funeral Home-2205 No. E. St. Louis, Ill.					25. DATE RECD. BY LOCAL REG. APR 14 1961		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>			

DATE AMENDED  
BY  
ITEM NO. SHOULD READ  
BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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 Thomas M. Nelson

Licensed Embalmer No. 4479  
P. O. Address East St. Louis, Ill.

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.