

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

318
 Registered District No. 1003
 Primary Registration District No. 8452
 SEP 21 1961

8452
 -61-034072
 STATE FILE NUMBER

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

| | | | | | | | |
|--|--|---|--|---|--|--|----------------------------------|
| 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 St. Louis, Mo. | | | | Length of stay in 1b | | c. CITY OR TOWN Jacksonville | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital | | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 223 Hardin, St. | |
| 3. NAME OF DECEASED (Type or print) First John Middle R. Last Brazelton | | | | 4. DATE OF DEATH Month Sept. Day 9, Year 1961 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 8/17/1917 | |
| 9. AGE (last birthday) 44 | | IF UNDER 1 YEAR Months 44 Days 0 Hours 0 Min. 0 | | IF UNDER 24 HR Months 0 Days 0 Hours 0 Min. 0 | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Quincy, Illinois. | |
| 13a. FATHER'S NAME Roy M. Brazelton | | | | 13b. MOTHER'S MAIDEN NAME Leta Cannon | | 14. NAME OF HUSBAND OR WIFE Nil. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) Yes W.W.# 2 | | | | 17. INFORMANT Address Leta Brazelton, Jacksonville, Illinois. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoidal Hemorrhage extensive; Bilateral Pulmonary Edema; suffered in auto accident DUE TO (b) in vicinity of Quincy, Illinois on Sept. 6, 1961. Cause and manner of same could not be determined. DUE TO (c) OPEN VERDICT | | | | | | | 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) 825-4-33 | | | | | 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 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.) See above | | | |
| 20c. TIME OF INJURY Hour 9 a.m. 6 p.m. | | Month, Day, Year 9-6-61 | | 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.) 7 1/2 Highway | |
| 20f. CITY, TOWN, OR LOCATION Quincy, Illinois | | COUNTY | | STATE | | | |
| 21. I attended the deceased from 325 A to her and last saw him alive on him | | | | Death occurred at 325 A m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) James M. Beeman, Deputy Coroner | | | | 22b. ADDRESS 1300 Clark | | 22c. DATE SIGNED 9-11-61 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 9-12-61 | | 23c. NAME OF CEMETERY OR CREMATORY Quincy Memorial Park Cem. | | 23d. LOCATION (City, town, or county) (State) Quincy, Illinois. | |
| 24. FUNERAL DIRECTOR ADDRESS Walter Hansen Funeral Home, Quincy, Ill. | | | | 25. DATE RECD. BY LOCAL REG. SEP 11 1961 | | 26. REGISTRAR'S SIGNATURE Loan Smith, M.D. | |

MEDICAL CERTIFICATION

BY (SEIDAVIT OF

SEP 28 1961

OCT 23 1961

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 *John J. Haines*
Licensed Embalmer No. 4108

P. O. Address St Louis MO

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.