

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

Registration District No. _____ Primary Registration District No. _____

1003

Registrar's No. _____

12188

-61-046117

STATE FILE NUMBER

AMENDED

FILED JAN 11 1962

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | c. CITY OR TOWN St. Louis | |
| Length of stay in 1b | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1610A N. Elliott | | d. STREET ADDRESS (If outside, give location) 1610A N. Elliott | |
| Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Lela Mae Briscoe | | | 4. DATE OF DEATH Month Day Year 12- 25 61 |
| 5. SEX Female | 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 2-14-1908 |
| 9. AGE (last birthday) 53 | | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (City and state or country) Corinth, Miss. | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Robert Berry | | 13b. MOTHER'S MAIDEN NAME Mollie ? | |
| 14. NAME OF HUSBAND OR WIFE Melvin Briscoe | | 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 Melvin Briscoe 1610A N. Elliott | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia; Second findings, - a large Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) uterine Fibroid; Arteriosclerosis, DUE TO (c) generalized; Sanguine, probably arteriosclerotic in nature. | | | 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. | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 450.1 | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ 12:30 P m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Paul Simon (Degree of _____) | | 22b. ADDRESS 1300 Clark | |
| 22c. DATE SIGNED 12/27/61 (State) | | 22d. DATE SIGNED | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 12-30-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Greenwood, Cemetery | | 23d. LOCATION (City, town, or county) St. Louis, Missouri | |
| 24. FUNERAL DIRECTOR A. L. Beal Und. Co. 4303 Delmar | | 25. DATE RECD. BY LOCAL REG. DEC 27 1961 | |
| 26. REGISTRAR'S SIGNATURE Loed Smith. M.D. | | 26. REGISTRAR'S SIGNATURE | |

STATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 Arthur L. Hillia

Licensed Embalmer No. 4221

P. O. Address 3100 East

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.