

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-047094

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3541

FILED DEC 18 1961

AMENDED

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CHAYTON</u>		c. CITY OR TOWN <u>2465 BROWN HA</u>	
Length of stay in lb <u>2da</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis Co Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>THORISSANT, Mo</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Brown</u> Last <u>Brown</u>			4. DATE OF DEATH Month <u>12</u> Day <u>12</u> Year <u>1961</u>		
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5. SEX <u>FEM</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3/22/86</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>HANNIBAH, MO</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>FRANK Ditto</u>	13b. MOTHER'S MAIDEN NAME <u>ANNIE ABLE</u>	14. NAME OF HUSBAND OR WIFE <u>-</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>MABEL DERRINGTON OVERLAND, MO</u>	Address <u>OVERLAND, MO</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>Encephalomalacia (S) temporal-parietal</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<u>Cerebral thrombosis</u> <u>Cerebral arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized arteriosclerosis</u>		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.)
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20c. TIME OF INJURY Hour <u> </u> Month, Day, Year <u> </u>	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
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21. I attended the deceased from <u>Dec. 11, 1961</u> to <u>Dec 12, 1961</u> and last saw her alive on <u>Dec 12, 1961</u> Death occurred at <u>8:20p</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>A. D. Howe MD</u> (Degree or title)	22b. ADDRESS <u>601 S. Brentwood, Chayton, Mo</u>	22c. DATE SIGNED <u>12/12/61</u>
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23a. BURIAL, CREMATION, REMOVAL, (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>12/15/61</u>	<u>SACRED HEART CEM.</u>	<u>THORISSANT, MO</u>

24. FUNERAL DIRECTOR <u>ORTMAN F. HOME</u> ADDRESS <u>9222 HACKLAND</u>	25. DATE RECD. BY LOCAL REG. <u>12-13-61</u>	26. REGISTRAR'S SIGNATURE <u>J. C. Murphy</u>
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STATE PARTIES OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

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 *AC Ostman*

Licensed Embalmer No. 3478

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.

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