

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-003521

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 970

AMENDED

FILED JAN 25 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>RANDOLPH</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>	Length of stay in 1b <u>19 days</u>	c. CITY OR TOWN <u>Chester</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-Little Rock Hospital, Inc.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>995 A State St.</u>

3. NAME OF DECEASED (Type or print) First <u>Arnold</u> Middle <u>Herman</u> Last <u>Brands</u>	4. DATE OF DEATH Month <u>January</u> Day <u>20</u> Year <u>1962</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-29-1890</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Police Station Agent</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (City and state or country) <u>PRAIRIE DU ROCHER, ILL</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>UNKNOWN</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>Lillian</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>Yes 1907</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>P. E. Brands</u> Address <u>St. Louis Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease with Terminal Failure</u>	INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>420.0</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary Emphysema Urinary bladder lithiasis</u>	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
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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 _____ a.m. _____ p.m.	Month, Day, Year _____
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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 <u>CHESTER</u>	COUNTY <u>ILLINOIS</u>	STATE <u>ILLINOIS</u>
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21. I attended the deceased from January 2, 1962 to January 20, 1962 and last saw him alive on January 20, 1962
Death occurred at 2:20 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>R. W. Casey M.D.</u>	(Degree or title)	22b. ADDRESS <u>1755 S. Grand Blvd.</u>	22c. DATE SIGNED <u>1/21/62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-23-62</u>	23b. DATE <u>1-23-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Marys Catholic Cem.</u>	23d. LOCATION (City, town, or county) <u>CHESTER</u>	23e. STATE <u>ILL</u>
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24. FUNERAL DIRECTOR <u>Weigel Funeral Home, Chester, Ill.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>JAN 22 1962</u>	26. REGISTRAR'S SIGNATURE <u>Loel Smith M.D.</u>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

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 *Not Embalmed*, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signed *Harold P. Keworth*

Signature of Student Embalmer

Licensed Embalmer No. *Kassly F. 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.