

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-004829

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 246

AMENDED

FILED JAN 29 1962

1. PLACE OF DEATH a. COUNTY <u>County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>BT Lewis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton Mo.</u>		Length of stay in lb <u>2 DAYS</u>	c. CITY OR TOWN <u>Manchester</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>County Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Bopp Nursing Home</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Blanche</u> Middle <u>Brown</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>15</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</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>7/10/1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pension</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pension</u>	9. AGE (last birthday) <u>71</u>
11. BIRTHPLACE (City and state or country) <u>Montree Tenn</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>James Brown</u>		13b. MOTHER'S MAIDEN NAME <u>Celia Johnson</u>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Fay Webb</u> Address <u>5308a Maple St</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary emboli - multiple</u> DUE TO (b) <u>Thrombophlebitis femoral veins</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			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) <u>Bronchopneumonia, Generalized arterosclerosis</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.)	
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 <u>Jan. 13, 1962</u> to <u>Jan. 15, 1962</u> and last saw her alive on <u>Jan. 15, 1962</u> . Death occurred at <u>9:50 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Albert L. Howe MD</u> (Degree or title)		22b. ADDRESS <u>601 S. Brentwood</u>	
22c. DATE SIGNED <u>1/15/62</u>		22d. STATE <u>Mo.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/20/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakdale Cemetery</u>	23d. LOCATION (City, town, or county) <u>Lemay Mo.</u>
24. FUNERAL DIRECTOR <u>HILL & RADFORD MOR. 1713 N. GRAND</u>		25. DATE RECD. BY LOCAL REG. <u>1-18-62</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Larry W. Darnis

Licensed Embalmer No. 4523

P. O. Address 4251 W...

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.