

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

11377 -62-044017  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. \_\_\_\_\_

**FILED NOV 30 1962**

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF
1						
2 <u>2/2</u>						
3						
4 <u>1</u>						
5 <u>0</u>						
6						
7 <u>0</u>						
8 <u>1</u>						
9						
10						
11						
12 <u>52-0</u>						
13						
<b>52</b>	SHOULD READ					

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	
		<b>ST. LOUIS, MISSOURI</b>		<b>Life</b>	<b>Mo</b>		<b>Mo</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<b>BARNES HOSPITAL</b>					<b>4907 West Pine Blvd</b>			
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH Month Day Year		
			<b>IOLA</b>	<b>FRANCES</b>	<b>BROCH</b>	<b>NOVEMBER 26 1962</b>		
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.
<b>Female</b>	<b>White</b>		<b>2/16/1908</b>	<b>54</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY		
<b>School Teacher</b>		<b>St. L. Public Schools</b>		<b>St. Louis, Missouri</b>		<b>U.S.A.</b>		
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE		
<b>Albert Broch</b>			<b>Bessie Lee</b>			<b>None</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address			
<b>No</b>			<b>None</b>		<b>Mrs Mabel Brown # 6 Ranch View Drive</b>			
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) <b>METASTATIC CARCINOMA OF BREAST</b>								<b>2 YEARS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								
DUE TO (b) _____								
DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						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 <b>AUG. 4, 1954</b> to <b>NOV. 26, 1962</b> and last saw her/him alive on <b>NOVEMBER 26, 1962</b> Death occurred at _____ <b>7:20 A.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title)					22b. ADDRESS		22c. DATE SIGNED	
<i>C. O. Verillia, M.D.</i>					<b>BARNES HOSPITAL</b>		<b>11/26/62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)		
<b>Cremation</b>		<b>11/28/62</b>		<b>Oak Grove Crematory</b>		<b>St. Louis Co. Missouri</b>		
24. FUNERAL DIRECTOR ADDRESS				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE		
<b>Alexander &amp; Sons 6175 Delmar Blvd</b>				<b>NOV 27 1962</b>		<i>Roan Smith, M.D.</i>		

**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 James E. McEwen

Licensed Embalmer No. 24600

P. O. Address 1308 Kings

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.