

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-048921

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3656

FILED JAN 10 1968

DO NOT WRITE ON THIS STUB

AMENDED

| |
|----------------|
| VS 300 |
| Rev. 4/59 |
| 1 <u>4002</u> |
| 2 <u>4000</u> |
| 3 <u>2</u> |
| 4 <u>1</u> |
| 5 <u>1</u> |
| 6 |
| 7 <u>0</u> |
| 8 <u>0</u> |
| 9 <u>465X</u> |
| 10 |
| 11 |
| 12 <u>45-0</u> |
| 13 |

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

| | | | |
|--|---|---|---|
| 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>Clayton</u> | | Length of stay in 1b <u>2 Days</u> | c. CITY OR TOWN <u>Maryland Hts.</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> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>214 Shoemaker</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Lucille Brewer</u> | | | 4. DATE OF DEATH Month Day Year <u>12-14-62</u> |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</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>4-16-05</u> |
| 9. AGE (last birthday) <u>57</u> | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
| 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>None</u> | 11. BIRTHPLACE (City and state or country) <u>DeSoto MO</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>James Metts</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Elmina Dodson</u> | | 14. NAME OF HUSBAND OR WIFE <u>Harvey Brewer</u> | |
| 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>Fernan Metts</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>Bilateral, Massive Pulmonary Thromboembolization</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. (b) <u>Acute Passive Abdominal Visceral Congestion</u> DUE TO (c) | | 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>Marked Exogenous Obesity, Left Adrenal Cortical Adenoma</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 type="checkbox"/> NO <input checked="" 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 checked="" 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>12-13-62</u> to <u>12-14-62</u> and last saw her <u>alive</u> on <u>12-14-62</u> Death occurred at <u>11:45 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>H.R. Gilcrest, M.D.</u> | | 22b. ADDRESS <u>601 So. Brentwood Clayton 5, Mo.</u> | 22c. DATE SIGNED <u>12/15/62</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE <u>12-18-62</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>CITY</u> | 23d. LOCATION (City, town, or county) (State) <u>DeSoto Mo.</u> |
| 24. FUNERAL DIRECTOR <u>J.L. Mothershead - DeSoto Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>12-15-62</u> | 26. REGISTRAR'S SIGNATURE <u>J. B. Murphy</u> |

USE BLACK INK OR TYPEWRITER RIBBON

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 Andrew H England

Licensed Embalmer No. 4745

P. O. Address DeSoto Mo

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.

4745