

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-003255

STATE FILE NUMBER

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **449**

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2213 S. 12th</b>		d. STREET ADDRESS (If outside, give location) <b>2213 S. 12th</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES HENRY BRAND</b>			4. DATE OF DEATH Month Day Year <b>JAN. 14 1963</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 19 1894</b>
9. AGE (last birthday) <b>78</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAINTENANCE MAN</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11a. BIRTHPLACE (City and state or country) <b>MO.</b>		11b. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>HARVEY BRAND</b>		13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
14. NAME OF HUSBAND OR WIFE <b>MAMIE BRAND</b>		17. INFORMANT <b>MAMIE BRAND RT. 1 BOX 379 CADET</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b> ) DUE TO (b) <b>Generalized Arteriosclerosis</b> <b>5 years</b> DUE TO (c) <b>420 OF</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in Part I. <b>Became much worse after being struck by lightning, Sept 3, 1962, shortly</b>			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
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.			
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>Jan 3, 1963</b> <b>Leroy E. Elison</b> to <b>Jan 14, 1963</b> and last saw him alive on <b>Jan 4, 1963</b> Death occurred at <b>4:30</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Leroy E. Elison MD</b>		22b. ADDRESS <b>3610 S. Broadway</b>	
22c. DATE <b>JAN 15 1963</b>		22d. DATE <b>JAN 15 1963</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>1/16/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>DESLOGE MO.</b>
24. FUNERAL DIRECTOR <b>Thomas Huter 2906 Francis</b>		25. DATE RECD. BY LOCAL REG. <b>JAN 15 1963</b>	
26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>			

FILED JAN 22 1963

**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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 Garois

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.

Dr  
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At Billie McRae  
3610 S Highway  
RR 6-4683  
11-4 Ave