

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25041
Registrar's No. 1985

Filed AUG 11 1945 Primary Registration District No. 2002

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town University City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Res: 7624 Cornell Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (years, months or days)

3. (a) PRINT FULL NAME EUGENE ROBERT LIVINGSTONE
3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Anna Hospes Livingstone 6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased December 16, 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 7 21 hr. min.

9. Birthplace Columbia, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Watchman

11. Industry or business _____

MOTHER FATHER { 12. Name William Livingstone
13. Birthplace Unknown England
(City, town, or county) (State or foreign country)
14. Maiden name Alice Kennard
15. Birthplace Unknown, Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Dorothy Hecker
(b) Address 7624 Cornell Ave

17. (a) Burial (b) Date thereof 8/9/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bellefontaine Cemetery

18. (a) Signature of funeral director C.R. Lupton & Sons

(b) Address 7233 Delmar Bly'd

19. (a) 8-9-45 (b) E. J. M. Gorman M.D.
(Date received local registrar) (Registrar's signature) msa

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town University City
(If outside city or town limits, write "RURAL")
(d) Street No. 7624 Cornell Ave
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 7th
year 1945 hour 11:30 minute 0 M.
21. I hereby certify that I attended the deceased from Feb 3
1965 to aug 7 1945
that I last saw him alive on aug 7 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis
Due to 940

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature Walter R. Hewitt (M. D. or other) _____
While at work _____ (Specify type of place) (e) Means of injury _____
Address 7649 Delmar Date signed aug 7/45

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

Dr Walter R. Hewitt:
7649 Delmar Blvd,
DE: 5650.
2 to 4 P.M.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Bradford A. Miles
Licensed Embalmer No. 2901
P. O. Address University City - 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 this body is not embalmed, fact should be so stated above.