

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6346**  
**798**  
Registrar's No. **798**

FILED FEB 17 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo</b>		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis State Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>5100 Arsenal Street 2129</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Thomas</b> b. (Middle) <b>Darden</b> c. (Last) <b>Darden</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Jan. 22, 1956</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negroid</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	
8. DATE OF BIRTH <b>1902-10-2</b>		9. AGE (In years last birthday) <b>53</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>20</b> IF UNDER 24 HRS. Hours <b></b> Mins. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Freight handler</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>Georgia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Will Darden</b>		13b. MOTHER'S MAIDEN NAME <b>Georgia Gaines</b>	
14. NAME OF HUSBAND OR WIFE <b>Deceased</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. _____	
17. INFORMANT'S SIGNATURE OR NAME <b>Irving Darden</b>		ADDRESS <b>2100 A. Carr Street</b>			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  *This does not mean the mode of dying, such as heart failure, asthma etc. It means the disease, injury, or complication which caused death.		<p align="center"><b>MEDICAL CERTIFICATION</b></p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Lungs, Tuberculous pneumonia, advanced with miliary spread to spleen and liver.</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Lung, left upper lobe, tuberculosis, fibrocaceous with cavitation.</b> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>General paresis of the insane</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs. plus</b>	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR	

22. I hereby certify that I attended the deceased from May 18 1953, to January 22 1956, that I last saw the deceased alive on Jan. 22 1956, and that death occurred at 9:15 a.m., from the causes and on the date stated above.

23a. SIGNATURE <b>L. H. Hoistetter</b> (Degree or title) <b>M.D.</b>		23b. ADDRESS <b>5100 Arsenal Street</b>		23c. DATE SIGNED <b>1-23-56</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>1-28-56</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	
24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>					

DATE REC'D BY LOCAL REG. <b>JAN 24 1956</b>		REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Ellis Funeral Home, Inc.</b> ADDRESS <b>2820 Stoddard St.</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *F. E. Cullin*.....

Licensed Embalmer No. *4198*.....

P. O. Address *W. H. ...*.....

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.