

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18804

STATE FILE NUMBER

FILED JUN 14 1957

318

1003

5294

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS MO.		c. CITY OR TOWN Saint Louis	
c. FULL NAME OF (If NOT in hospital, give location) INSTITUTION ST LOUIS CITY HOSP. #1		d. STREET ADDRESS (If outside, give location) 1072 4642 Ashland Ave.	

3. NAME OF DECEASED (Type or print) First JESSE Middle LEE Last HILL			4. DATE OF DEATH Month 6 Day 3 Year 57		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1910	9. AGE (In years last birthday) 46	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Table Waiter		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Robinson Co., Tenn.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Henry Hill			14. MOTHER'S MAIDEN NAME Beulah Long		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -310-01-5134	17. INFORMANT Address Mrs. Beulah Hill 4642 Ashland Ave.		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Decubiti		
DUE TO (c) Hipomao & Spinalcord		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)		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.) 226x	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.	20d. 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 **4-26-57** to **6-3-57** and last saw her alive on **6-3-57**
Death occurred at **11:00 P. m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree of title) Stuart A. Gaff, MD	22b. ADDRESS 1515 LAFAYETTE	22c. DATE SIGNED 6-6-57
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6-6-57	23c. NAME OF CEMETERY OR CREMATORY Saint Peters Cemetery Saint Louis Co. Mo.	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR ADDRESS Metropolitan Funeral System, Inc. 5010 Enright Avenue	25. DATE RECD. BY LOCAL REG. JUN 6 57	25. REGISTRAR'S SIGNATURE Carl Smith	

(Licensed Embalmer's Statement on Reverse Side)

Do not use only standard nomenclature in item 18. The symptoms which be listed on this certificate must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *John T. Cunningham*

Licensed Embalmer No. 44

P. O. Address 2405 9th

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.