

FILED AUG 5 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26962

STATE FILE NUMBER

Registration District No. 312 Primary Registration District No. 590 Registrar's No. 1780

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Ann</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>St. Ann</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3720 Adie Rd.</u>			Length of stay in lb <u>9 Years</u>		d. STREET ADDRESS <u>3720 Adie Rd.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH					
First Middle Last <u>Joseph King Sr.</u>				Month Day Year <u>July 13, 1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</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>Oct 21, 1897</u>		9. AGE (In years last birthday) <u>59</u>	
IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taxie Cab Driver</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Joseph King</u>				14. MOTHER'S MAIDEN NAME <u>Anna Steainbank</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>489-14-3044</u>		17. INFORMANT Address <u>Della King 3720 Adie Rd. St. Ann Mo.</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>Acute Myocardial Failure</u> DUE TO (b) <u>Chronic Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Active Duodenal Ulcer.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) <u>4200</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 d</u> <u>1 yr.</u> <u>6 mos.</u>	
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.) <u>4200</u>						
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 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>Nov. 20, 1956</u> to <u>July 13, 1957</u> and last saw her alive on <u>7/13/57</u> Death occurred at <u>7 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Joseph B. Succione MA</u>				22b. ADDRESS <u>2801 N. Taylor</u>				22c. DATE SIGNED <u>7/15/57</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)	
<u>Buried</u>		<u>7/16/1957</u>		<u>Calvary Cemetery</u>		<u>St. Louis</u>		<u>Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Collier Mortuary St. Ann, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>7/15/57</u>		26. REGISTRAR'S SIGNATURE <u>Dubert B. Donk</u>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

300
1-56Health
Welfare
Public
Service

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 *Sheldon Collier*.....

Licensed Embalmer No. *33*

P. O. Address *St. Ann*

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.