

Health,
Welfare
Public
Service

FILED NOV 5 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37364
STATE FILE NUMBER
10172
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS, Mo</u>		c. CITY OR TOWN <u>CHICAGO</u> <u>812th St</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MISSOURI PACIFIC</u>		d. STREET ADDRESS <u>6604 So GREENWOOD.</u>	
Length of stay in lb <u>15 days</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>CURTIS BUSTER DRAPER</u>			4. DATE OF DEATH Month Day Year <u>10 29 57</u>			
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5. SEX <u>M</u>	6. COLOR OR RACE <u>C</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>1/16/1909</u>	9. AGE (In years less birthday) <u>48</u>	10. FUNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PALOR CAR ATT.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD.</u>	11. BIRTHPLACE (City and state or country) <u>Springfield, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Cortes Draper</u>	13b. MOTHER'S MAIDEN NAME <u>Bethenia Lynn</u>	14. NAME OF HUSBAND OR WIFE <u>MAGGIE.</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <u>711-03-6439</u>	17. INFORMANT <u>Alberta Draper Brooks, 1627 Lawrence</u>	Address
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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>BRONCHO PNEUMONIA, CONFLUENT</u>		Chicago, Illinois	INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>BRAIN ABCESS, L. PARGITAL, DEV TO BETA</u>		<u>3 wks.</u>
	DUE TO (c) <u>HEMOLYTIC STREPTOCOCCUS</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour Month, Day, Year 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
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21. I attended the deceased from <u>Oct 13</u> to <u>Oct 29</u> and last saw her alive on <u>10/29/57</u> Death occurred at <u>2:20 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Geo. Hawkins (Degree or title) M.D.</u>	22b. ADDRESS <u>100 N. Euclid</u>	22c. DATE SIGNED <u>Oct 29, '57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-30-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Springfield, Illinois</u>
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24. FUNERAL DIRECTOR <u>Charles J. Gates, 4107 Finney Ave.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>OCT 30 '57</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

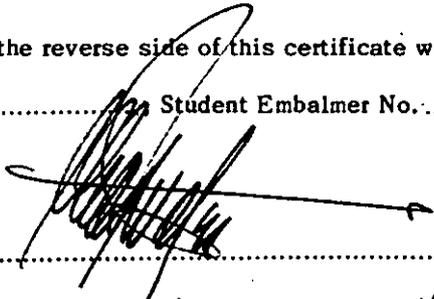
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 

Licensed Embalmer No. 1845

P. O. Address 4107 Finney Ave

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.