

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41693**
11659

FILED DEC 13 1957

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** 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, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	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 (If not in hospital or institution, give street address or location) 3/ St. Louis State Hospital		e. STREET ADDRESS (If rural, give location) 2/ 3119 Washington Avenue	

3. NAME OF DECEASED (Type or Print) a. (First) Joseph b. (Middle) Andfield c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) November 16, 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH 3-15-09
9. AGE (In years last birthday) 48	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Hours	IF UNDER 15 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Georgia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph	

13b. MOTHER'S MAIDEN NAME Minnie Allen		14. NAME OF HUSBAND OR WIFE Virginia	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ?	16. SOCIAL SECURITY NO. ?	17. INFORMANT'S SIGNATURE OR NAME Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Portal Thrombophlebitis of liver		INTERVAL BETWEEN ONSET AND DEATH 2 mos.	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Malignant Bilat. exophthalmus, Thyroidectomy Ascites 2520	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. 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) (Min.)		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 **4-23**, **1945**, to **11-16**, **1957**, that I last saw the deceased alive on **11-16**, **1957**, and that death occurred at **1:40a. m.**, from the causes and on the date stated above.

23a. SIGNATURE L. Hofstetter, M.D.		23b. ADDRESS 5400 Arsenal Street		23c. DATE SIGNED 11-16-57	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 12-31-57		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Rowland-Aker Mortuary Service			

DATE REC'D BY LOCAL REG. DEC 5 57		REGISTRAR'S SIGNATURE Carl Smith Mo		ADDRESS 4181 Manchester Ave. St. Louis 10, Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

(Licensed Embalmer's Statement on Reverse Side)

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.....

P. O. Address.....

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.