

Health,  
& Welfare  
Public  
Service

S. 300  
v. 1-56

Securing the medical certification in the specific manner required by 193.140 MOKS 1949.  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I. must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED DEC 13 1957

STANDARD CERTIFICATE OF DEATH

42619

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11507**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>City Hosp.</b>		Length of stay in 1b	223 <sup>1/2</sup> STREET ADDRESS <b>2715 S. Jefferson</b> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>Byrd</b> Last <b>Sinks</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>1</b> Year <b>1957</b>		
5. SEX <b>Male</b> <input type="checkbox"/>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 10 1876</b>	9. AGE (In years last birthday) <b>81</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance Broker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Kentucky</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Unknown Sinks</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</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. <b>311-03-0501</b>	17. INFORMANT Address <b>Walter S. Sinks 2643 Russell A.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Hip</b> DUE TO (b) <b>Hypertension.</b> DUE TO (c) Conditions, if any, which gave rise to above cause (b), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <b>E904.0 21</b>					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II of Part II of Item 18.) <b>While he fell at home, at 2715 South Jefferson on December 2nd 1957</b>			
20c. TIME OF INJURY Hour Month, Day, Year a. m. <b>12</b> p. m. <b>257</b>		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>23 Maple</b>			
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <b>St. Louis Mo</b>		COUNTY STATE	
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at <b>525 1/2</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Arthur E. Dyer 3</b>			22b. ADDRESS <b>1300 Elvaca</b>		22c. DATE SIGNED <b>12/1/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>12-4-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New St. Marcys Cem</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Mo. Mo.</b>
24. FUNERAL DIRECTOR <b>With Bro. L. H. Co. 2929 S. Jefferson</b>		ADDRESS <b>DEC 2 '57</b>		25. DATE RECD. BY LOCAL REG. 26. REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b> <b>m. &amp; B.</b>	

(Licensed Embalmer's Statement on Reverse Side)

8701

819

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 *Harold C. Witt* .....

Licensed Embalmer No. *435*

P. O. Address *St. Louis,*

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.