

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-016828
STATE FILE NUMBER

FILED MAY 12 1958

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 1173

4007

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>WEBSTER GROVES</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>WEBSTER GROVES</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>125 REASONOR</u> Length of stay in lb <u>3</u>		d. STREET ADDRESS (If outside, give location) <u>125 REASONOR</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>FAY</u> Last <u>WASHINGTON</u>			4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 25, 1953</u>	9. AGE (In years last birthday) <u>5</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>GRENADA MISSISSIPPI</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>PAUL WASHINGTON</u>	14. MOTHER'S MAIDEN NAME <u>ORA LEE JEFFERSON</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <u>NO</u> (If yes, give year or dates of service)	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>Paul Washington 125 Reasonor</u> Address	

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>Due to burns</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) <u>E916.0</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>16</u>		19. WAS AUTOPSY PERFORMED? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 I or Part II of item 18.) <u>Burned in fire in home</u>	
20c. TIME OF INJURY Hour <u>8:30</u> approx. Month <u>4</u> Day <u>25</u> Year <u>58</u>		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>bedroom of home</u>	20f. CITY, TOWN, OR LOCATION <u>Webster Groves</u> COUNTY <u>St. Louis</u> STATE <u>Mo.</u>
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>Raymond L. Laird</u> Coroner	22b. ADDRESS <u>Clayton, Missouri</u>	22c. DATE SIGNED <u>5/1/58</u>

23a. BURIAL CREATION (Funeral Society)	23b. DATE <u>April 30, 58</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Father Neekens</u>	23d. LOCATION (City, town, or county) (State) <u>Crestwood Mo</u>
24. FUNERAL DIRECTOR <u>J. J. Spudea & Sons</u> ADDRESS <u>1778</u>	25. DATE RECD. BY LOCAL REG. <u>4-29-58</u>	26. REGISTRAR'S SIGNATURE <u>Herbert R. Dumble MD</u>	

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

89.

STATEMENT BY LICENSED EMBALMER *A*

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. *46*

P. O. Address *308*

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.