

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-020074

STATE FILE NUMBER 4693

FILED MAY 26 1958

Registration District No. 318 Primary Registration District No. 1003 Registrator's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY <u>ST. CLAIR</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>32 E. ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST LOUIS - HITTLE ROCK HOSPITAL</u>				Length of stay in lb <u>027 days</u>		d. STREET ADDRESS (If outside, give location) <u>2141 MARKET AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>PETER</u> Middle <u>ZACK</u> Last <u>RICH</u>				4. DATE OF DEATH Month <u>4</u> Day <u>29</u> Year <u>58</u>			
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>SEPT. 5, 1910</u>		9. AGE (In years last birthday) <u>47</u>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD AITON + SOTHERN</u>		11. BIRTHPLACE (City and state or country) <u>WAYNESBORO, MISS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>TOM RICH</u>				14. MOTHER'S MAIDEN NAME <u>SEVETTA WILSON</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>437-10-5393</u>		17. INFORMANT <u>Alyce Rich</u>		Address <u>2141 MARKET</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>BRONCHITIS PNEUMONIA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>POST-OPERATIVE RESECTION OF STERNUM</u> <u>19 DAYS</u>	
						DUE TO (c) <u>ENCHONDROMA OF STERNUM.</u> <u>1 YEAR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>225X</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.)				
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	
21. I attended the deceased from <u>APRIL 2nd '58</u> and last saw him alive on <u>APRIL 28th '58</u> Death occurred at <u>6:10 A. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>James C. Vest M.D.</u>				22b. ADDRESS <u>634 N Grand</u>		22c. DATE SIGNED <u>4/29/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>4/30/58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Booker Washington</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Illinois</u>	
24. FUNERAL DIRECTOR <u>Marion's Office</u> ADDRESS <u>2114 Missouri E. ST. LOUIS, ILL.</u>				25. DATE RECD. BY LOCAL REG. <u>MAY 1 '58</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>	

(Licensed Embalmer's Statement on Reverse Side)

path, Welfare public service  
300  
1-56  
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms written on certificate.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Frank Prokop*.....

Licensed Embalmer No. 434

P. O. Address *St. Louis*.....

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.