

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-034498
STATE FILE NUMBER
8162

#2017-001
FILED OCT 10 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8162

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS, MO
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHNS HOSPITAL		Length of stay in lb P. WEEKS 039	d. STREET ADDRESS (If outside, give location) 6211 COLUMBIA
3. NAME OF DECEASED (Type or print) First MIDDLE LAST BILLY WAYNE MASSEY			4. DATE OF DEATH Month Day Year 8-21-1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-12-1958
9. AGE (In years last birthday) 29		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME ROY MASSEY	13b. MOTHER'S MAIDEN NAME RUBY FRAZIER
14. NAME OF HUSBAND OR WIFE NONE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE
17. INFORMANT ROY MASSEY		Address 6211 Columbia	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Spinal meningitis viral</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 340.3
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 <i>Aug 18</i> to <i>Aug 18</i> and last saw ^{her} / _{him} alive on <i>Aug 18</i> Death occurred at <i>4115A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>J. Catoyan M.D.</i>		22b. ADDRESS <i>2705 Clifton</i>	22c. DATE SIGNED <i>21 Aug 58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 8-22-58	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	23d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY, MO.
24. FUNERAL DIRECTOR ADDRESS HOWARD MICHAEL 6930 SOUTHWEST		25. DATE RECD. BY LOCAL REG. AUG 22 1958	26. REGISTRAR'S SIGNATURE <i>J. Paul Smith M.D.</i> S.P.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Henry Kable*

Licensed Embalmer No. *4596*
P. O. Address. *Teloussant*

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.