Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-042189
STATE FILE NUMBER

FILED DEC 1 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11170

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Louis City Hosp. #1 — Length of stay in lb 25
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN ST.LOUIS,MO. — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 2702 DELMAR — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Lonzolla Middle: Last: Sanders
4. DATE OF DEATH Month: Nov. Day: 6 Year: 1958
5. SEX: FEMALE 3
6. COLOR OR RACE: NEGRO
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/4/58
9. AGE (In years last birthday) IF UNDER 1 YEAR Months 2 1/3 Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): no
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (City and state or country): ST.LOUIS,MO.
12. CITIZEN OF WHAT COUNTRY? U.S.A
13a. FATHER'S NAME: UNKNOWN
13b. MOTHER'S MAIDEN NAME: BERNICE SANDERS
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO.: no
17. INFORMANT Address: ST.LOUIS CITY HOSP. #1.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septicemia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) genitourinary tract infection
DUE TO (c) 609X
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 Oct. 26, 1958, to Nov. 6, 1958 and last saw her/him alive on Nov. 6, 1958
Death occurred at 6:00 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Thomas R. Shrogge MD
22b. ADDRESS 1515 Lafayette
22c. DATE SIGNED 11/6/58

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE 11-29-58
23c. NAME OF CEMETERY OR CREMATORY Anatomical Board
23d. LOCATION (City, town, or county) (State) St. Louis, Mo.

24. FUNERAL DIRECTOR ADDRESS Rowland Aker 4104 Manchester
25. DATE RECD. BY LOCAL REG. NOV 20 '58
26. REGISTRAR'S SIGNATURE J Earl Smith MD MDB

(Licensed Embalmer's Statement on Reverse Side)

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 ..... Signed .....
Signature of Student Embalmer

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.