

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-042419

STATE FILE NUMBER

FILED DEC 1 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

11104

300

-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST LOUIS</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>OF BARNES HOSPITAL</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>217 2808 WASHINGTON</u>		Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>NMN</u> Last <u>WESLEY</u>			4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>15</u> Year <u>1958</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>UNKNOWN</u>	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <u>46.63</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PORTER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>BEACH, Miss.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>John Wesley</u>		13b. MOTHER'S MAIDEN NAME <u>ARTIE SLAUGHTER</u>		14. NAME OF HUSBAND OR WIFE <u>EMMA DECEASED</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>—</u>	17. INFORMANT Address <u>ROBERT BOWIE 5541 MAPLE</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>CEREBRAL VASCULAR ACCIDENT</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 MONTH</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CEREBRAL ARTERIOSCLEROSIS</u>					<u>1 YEAR</u>
DUE TO (c) <u>331X</u>					
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 <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 o.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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>Nov. 5, 1958</u> to <u>Nov. 15, 1958</u> and last saw her/him alive on <u>Nov. 15, 1958</u> Death occurred at <u>10:05 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>FR Bradley</u> (Degree or title) <u>M.D.</u>			22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>11/16/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>11-21-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD</u>		23d. LOCATION (City, town, or county) (State) <u>ST LOUIS CO MO</u>
24. FUNERAL DIRECTOR <u>Bennie Love</u> ADDRESS <u>3103 Washington</u>		25. DATE RECD. BY LOCAL REG. <u>NOV 18 '58</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> <u>mfb</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

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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 *W. Claude GOR*
W. CLAUDE GOR

Licensed Embalmer No. *348*
P. O. Address *4575 Ala*

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.