Health, Welfare Public Service

300
1-57

28
112

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002665

STATE FILE NUMBER 2 902

FILED FEB 10 1959

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Homer G. Phillips — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 2119 4352 Easton — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Clara — Middle: Mae — Last: Albertie

4. DATE OF DEATH: Month: 1 — Day: 24 — Year: 59

5. SEX: FeMale 3

6. COLOR OR RACE: Negro

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: June 30, 1918

9. AGE (In years last birthday): 40yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (City and state or country): Memphis Tenn.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Hardy Jackson

13b. MOTHER'S MAIDEN NAME: Maxine Stahlen

14. NAME OF HUSBAND OR WIFE: Garnett Albertie

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.: None

17. INFORMANT: Mrs. Maxine Jackson — Address: 4339 W. Aldine

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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): Uremia

DUE TO (b): chronic glomerular nephritis

DUE TO (c): 592x

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: undet.

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 ☒

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

All diseases in Part I must be causally related.

21. I attended the deceased from 1-12-59, to 1-24-59 and last saw her alive on 1-24-59. Death occurred at 8:15 p m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Paul Larson (Degree or title): Paul M. Larson, M.D.

22b. ADDRESS: 2601 Whittier Street

22c. DATE SIGNED: 1-26-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 1/30/59

23c. NAME OF CEMETERY OR CREMATORY: Washington Park

23d. LOCATION (City, town, or county) (State): St. Louis County Mo.

24. FUNERAL DIRECTOR: Herman J. Smith — ADDRESS: 4247 W. Labadie

25. DATE REC'D. BY LOCAL REG.: JAN 27 '59

26. REGISTRAR'S SIGNATURE: J. Earl Smith M.D. M. G. B.

(Licensed Embalmer's Statement on Reverse Side)

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 W. Claude Gord

Licensed Embalmer No. 3489

P. O. Address 4575 Ale

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.