

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002758
STATE FILE NUMBER
242

FILED JAN 26 1959

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

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Madison	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Venice
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Inf.		Length of stay in 1b 6 days	d. STREET ADDRESS (If outside, give location) 209 Roosevelt Rd.
3. NAME OF DECEASED (Type or print) First Middle Last LEE ELLA BOYD			4. DATE OF DEATH Month Day Year Jan 6, 1959
5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 28, 1904
9. AGE (In years last birthday) 54		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and state or country) Memphis, Tenn.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Linnie Green		15. NAME OF HUSBAND OR WIFE Henry Boyd	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. None	18. INFORMANT Henry Boyd-209 Roosevelt Road
19. 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 thrombosis</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>332XH</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Melanoma, diabetes</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> stage
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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <u>December 30, 1958</u> to <u>January 6, 1959</u> and last saw her alive on <u>January 6, 1959</u> Death occurred at <u>P. M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Earle Willson M.D.</u> (Degree or title)		22b. ADDRESS <u>501 Madison, Quincy, Ill.</u>	22c. DATE SIGNED <u>January 7, 1959</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1-8-59	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) East St. Louis, Ill.
24. FUNERAL DIRECTOR Marshall Fun Home-E. St. Louis, Ill		25. DATE RECD. BY LOCAL REG. JAN 8 '59	26. REGISTRAR'S SIGNATURE <u>Earle Willson</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

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 *Thomas M. Robson*

Licensed Embalmer No.4479.....
P. O. Address East St. Louis,

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.