Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002847 STATE FILE NUMBER

FILED JAN 26 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 87

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): DePaul Hospital — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: Foristell — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): RR #1 Box 100 E. — Reside on Farm Yes ☐ No ☐

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3. NAME OF DECEASED (Type or print): First: CALEB Middle: STAFFARD Last: CUMMINS
4. DATE OF DEATH: Month: Jan. Day: 4 Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec.17,1889
9. AGE (In years last birthday): 69 — 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): Custodian-(Retired)
10b. KIND OF BUSINESS OR INDUSTRY: City Hospital
11. BIRTHPLACE (City and state or country): Barlow, Kentucky
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13a. FATHER'S NAME: Gus Cummins
13b. MOTHER'S MAIDEN NAME: Sarah Baker
14. NAME OF HUSBAND OR WIFE: Hallie Cummins
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes World war I
16. SOCIAL SECURITY NO.: 490-24-9738
17. INFORMANT: Hallie Cummins RR #1-Box 100 E. Address Foristell, Mo.

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): Bronchogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: Unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
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DUE TO (c):
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.)
ITEM 22c CORRECTED BY AFFIDAVIT OF Physician 2-9-59
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 Nov 24th 1958 to Jan 4 1959 and last saw her/him alive on Jan 3, 1959
Death occurred at 3:30 A. m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: H H Feller M.D. (Degree or Title)
22b. ADDRESS: 2739 N. Grand
22c. DATE SIGNED: 1-5-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Jan.7,1959
23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis Co. Mo.

24. FUNERAL DIRECTOR: Kriegshauser ADDRESS: 4228 S.Kingshighway
25. DATE RECD. BY LOCAL REG.: JAN 5 '59
26. REGISTRAR'S SIGNATURE: Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

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 William B. White

Licensed Embalmer No. [illegible]

P. O. Address [illegible]

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.