

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003064
State File No.

FILED JAN 26 1959

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 29

1. PLACE OF DEATH a. COUNTY Masonic Home of Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Masonic Home of Missouri		d. STREET ADDRESS (If rural, give location) 2129 5351 Delmar Boulevard	
3. NAME OF DECEASED a. (First) Dee b. (Middle) Bedford c. (Last) High		4. DATE OF DEATH (Month) (Day) (Year) 1 1 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH Oct. 19, 1875
9. AGE (In years last birthday) 83		10. KIND OF BUSINESS OR INDUSTRY Barber	11. BIRTHPLACE (City and State or Foreign Country) Commerce, Missouri 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME James High		13b. MOTHER'S MAIDEN NAME Minnie Cooley	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Masonic Home of Mo. 5351 Delmar Blvd	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gastrointestinal bleeding (undetermined origin) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis DUE TO (c) 5728 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-56, 19, to 1-1, 1959, that I last saw the deceased alive on 12-31, 1958, and that death occurred at 12:50a m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Arnold E. Walters M.D.		23b. ADDRESS 3720 Washington St. Louis Mo.	
23c. DATE SIGNED 1-1-59			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 1-1-59	
24c. NAME OF CEMETERY OR CREMATORY Local		24d. LOCATION (City, town, or county) (State) Illmo Mo	
DATE REC'D BY LOCAL REG. JAN 3 59		REGISTRAR'S SIGNATURE J. Earl Smith M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe		ADDRESS 4700 Washington	

(H.T.) (Licensed Embalmer's Statement on Reverse Side)

MAY 8 1959

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
Student Embalmer

Signed *Lawrence O. Herling*

Licensed Embalmer No. *4979*

P. O. Address *St. Louis, Mo.*

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 this body is not embalmed, fact should be so stated above.