Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003069
STATE FILE NUMBER

FILED JAN 28 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 425

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri. b. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St.Louis — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN St. Louis. — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 458 N. Boyle Ave. — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 2199 458 N. Boyle, Ave. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: Chew — Middle: — Last: Him		4. DATE OF DEATH Month: January Day: 10 Year: 1959	
5. SEX: Male 4	6. COLOR OR RACE: Yellow	7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] 0 DIVORCED [ ]	8. DATE OF BIRTH: 9
9. AGE (In years last birthday): 55?	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): Laundry Owner	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (City and state or country): Canton, China 7	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: Unknown	13b. MOTHER'S MAIDEN NAME: Unknown	14. NAME OF HUSBAND OR WIFE: Nil.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service) Nil.	16. SOCIAL SECURITY NO.: None	17. INFORMANT: Charles Quinn, Address: 6314 Delmar	

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) Chronic Nephritis — INTERVAL BETWEEN ONSET AND DEATH 5-3 years

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

DUE TO (c) 492x

Cif. M. Lee
Jos. M. Lee
Dep. Cor. 1/13/59

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Generalized Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

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

21. I attended the deceased from Jan 9-1959, to Jan 10-1959 and last saw her/him alive on Jan 10-1959. Death occurred at 1-10-830 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Le Roy Loebbs Physician	22b. ADDRESS: 1420 N. Taylor Ave	22c. DATE SIGNED: 1-12-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal	23b. DATE: 1-13-59	23c. NAME OF CEMETERY OR CREMATORY: Valhalla Cemetery	23d. LOCATION (City, town, or county) (State): St. Louis County, Mo.
24. FUNERAL DIRECTOR: Albert H.Hoppe, ADDRESS: 4700 Washington Blvd.	25. DATE RECD. BY LOCAL REG.: JAN 13'59	26. REGISTRAR'S SIGNATURE: Earl Smith MD MJB.	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Melvin L. Kemper

Licensed Embalmer No. 4052

P. O. Address 4911 Washington 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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