

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003101  
STATE FILE NUMBER  
613

3 1959 Registration District No. Primary Registration District No. Registrar No.

300  
1-57  
3  
21  
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Missouri</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Length of stay in 1b <u>60 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>13 Portland Pl. (near)</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN WESLEY HUTCHINSON</u>	4. DATE OF DEATH Month Day Year <u>JANUARY 17, 1959</u>
---	---

5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 11, 1885</u>	9. AGE (In years last birthday) <u>74</u>	F 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) <u>Houseman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>	11. BIRTHPLACE (City and state or country) <u>Lebanon, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
--	--	--	---

13a. FATHER'S NAME <u>Samuel Hutchinson</u>	13b. MOTHER'S MAIDEN NAME <u>Laura White</u>	14. NAME OF HUSBAND OR WIFE <u>Betty Hutchinson</u>
--	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Hettie Ellis</u>	Address <u>5207 Maple Avenue</u>
--	-------------------------	--------------------------------------	-------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Volvulus of the small intestine</u>	INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>
---	--

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

DUE TO (b) \_\_\_\_\_

DUE TO (c) 570.3

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 <input checked="" type="checkbox"/> NO <input type="checkbox"/>
---	--	---

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. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK 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 <u>January 10, 1959</u> to <u>January 17, 1959</u> and last saw <u>him</u> alive on <u>January 17, 1959</u> Death occurred at <u>2:10 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE <u>F. R. Bradley</u> (Degree or title) <u>M. D.</u>	22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>1/17/59</u>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1/22/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>
---	-----------------------------	---	--

24. FUNERAL DIRECTOR <u>Charles J. Gates</u>	ADDRESS <u>4107 Finney</u>	25. DATE RECD. BY LOCAL REG. <u>JAN 19 59</u>	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u> <u>mds</u>
---	-------------------------------	--	--

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 ..... *George Swan* .....

Licensed Embalmer No. 4580 .....  
P. O. Address 4107 Finney Ave .....

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.