

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003152

STATE FILE NUMBER

2 972

FILED FEB 10 1959

Registration District No. _____ Primary Registration District No. _____

Registration No. _____

300
-57
08
66

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>2017</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis</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>Community</u>		Length of stay in 1b <u>4 days 7</u>	d. STREET ADDRESS (If outside, give location) <u>1342 N. Belt St</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Grover</u> Middle <u>George</u> Last <u>Kendall</u>			4. DATE OF DEATH Month <u>1</u> Day <u>23</u> Year <u>59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-8-1909</u>	9. AGE (In years last birthday) <u>49</u>	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) <u>labor</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Redfield Ark</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>Lucille Kendall.</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. <u>498-03-9021</u>	17. INFORMANT <u>Lucille Kendall</u>	Address <u>1342 N. Belt</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>1. Pulmonary Infarction;</u> <u>2. Oedema of the Brain;</u> 3. Multiple fractures; suffered when struck by car operated by unknown driver at intersection of Jefferson and Chouteau Aves., about 5:50 P.M., Jan. 14, 1959. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" 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.	<u>no</u>		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>St Louis</u>	COUNTY <u>St Louis</u>	STATE <u>MO</u>
--------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	-------------------------------------------------	---------------------------	--------------------

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at _____ 9:40P on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>George M. Dickson</u>	22b. ADDRESS <u>1300 Clack</u>	22c. DATE SIGNED <u>1/28/59</u>
--------------------------------------------	-----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-30-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON PARK</u>	23d. LOCATION (City, town, or county) <u>St Louis County</u>	(State) <u>MO</u>
------------------------------------------------------------	-----------------------------	--------------------------------------------------------------	-----------------------------------------------------------------	----------------------

24. FUNERAL DIRECTOR <u>Gus Howe</u>	ADDRESS <u>2930 Dickson St</u>	25. DATE RECD. BY LOCAL REG. <u>JAN 28 '59</u>	26. REGISTRAR'S SIGNATURE <u>Loal Smith, M.D.</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 Arthur L. Heilbard

Licensed Embalmer No. 4221

P. O. Address 3100 Easton

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.