

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003219

STATE FILE NUMBER

FILED FEB 3 1959 Registration District No. Primary Registration District No. Registrar No. 645

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1-57
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN Saint Louis,	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1		d. STREET ADDRESS 2131 Cole Street (If outside, give location)	
3. NAME OF DECEASED (Type or print) First Middle Last TOM LOVE		4. DATE OF DEATH Month Day Year JAN. 16, 1959	
5. SEX Male 2	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/15/1888
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) Baby		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Mississippi
12. CITIZEN OF WHAT COUNTRY? USA.		13a. FATHER'S NAME Nelson Love	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Deceased	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (No, give war or dates of service)		16. SOCIAL SECURITY NO. 487-18-2760	17. INFORMANT Mary Maxwell, 2131 Cole Street Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> <i>Cerebral arteriosclerosis</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>332x</i> 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 <i>2 wks.</i> <i>Not known</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 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 COUNTY STATE
21. I attended the deceased from <u>1/12/59</u> to <u>1/16/59</u> and last saw her/him alive on <u>1/16/59</u> Death occurred at <u>2:50 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <i>V.A. Codrigo M.D.</i>	
22b. ADDRESS 1515 LAFAYETTE AVE.		22c. DATE SIGNED 1/16/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1/21/59	23c. NAME OF CEMETERY OR CREMATORY Washington Park	23d. LOCATION (City, town, or county) (State) St. Louis, County Mo.
24. FUNERAL DIRECTOR Ellis Funeral Home, 2820 Stoddard St. ADDRESS		25. DATE RECD. BY LOCAL REG. JAN 19 1959	26. REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i> <i>m j b</i>

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 *Fulton C. Calkins*

Licensed Embalmer No. *498*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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