Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003237
STATE FILE NUMBER

FEB 10 1958 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 932

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Homer G. Phillips — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: ST. LOUIS — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 222 303 So. Jefferson — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Andrew — Middle: — Last: McGee

4. DATE OF DEATH: Month 1 — Day 24 — Year 59

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 9-11-1891

9. AGE (In years last birthday): 67 YRS — IF UNDER 1 YEAR: Months 4, Days 13 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NIGHT WATCHMAN

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): BALDWIN, MISS

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13a. FATHER'S NAME: NORA Mc Gee

13b. MOTHER'S MAIDEN NAME: MATTIE BOWDRY

14. NAME OF HUSBAND OR WIFE: DOSHIE Mc GEE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Doshie Mc Gee — Address: 303a So. Jeff. Av.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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): Diabetes Mellitus — INTERVAL BETWEEN ONSET AND DEATH: undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): 260
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Gangrene left foot, Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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 12-30-58, to 1-24-59 and last saw her/him alive on 1-24-59
Death occurred at 5:55 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE F. O. Richards (Degree or title), M.D.

22b. ADDRESS: 2601 Whittier Street

22c. DATE SIGNED: 1-26-59

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

23b. DATE: 1-29-59

23c. NAME OF CEMETERY OR CREMATORY: GREENWOOD CEM

23d. LOCATION (City, town, or county) (State): ST. LOUIS CTY MO

24. FUNERAL DIRECTOR: A. F. WALTON — ADDRESS: 2707 STODDARD ST.

25. DATE RECD. BY LOCAL REG.: JAN 27 59

26. REGISTRAR'S SIGNATURE: Carl Smith MD M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4525 Aldine

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.