Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003550
STATE FILE NUMBER

FILED FEB 10 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 898

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): Chronic Hosp. — Length of stay in Hospital: 3yr 5mo	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Mo. b. COUNTY: c. CITY OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐ d. STREET ADDRESS (If outside, give location): 2069 1375 Temple Pl. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Biddie Middle: Last: Strong

4. DATE OF DEATH: Month: Jan. Day: 22, Year: 1959

5. SEX: female 3

6. COLOR OR RACE: colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐

8. DATE OF BIRTH: 30 Mar. 1886

9. AGE (In years last birthday): 72 — 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): housewife

10b. KIND OF BUSINESS OR INDUSTRY: housewife

11. BIRTHPLACE (City and state or country): West Point, Miss. /

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

13a. FATHER'S NAME: John

13b. MOTHER'S MAIDEN NAME: Winnie Canada

14. NAME OF HUSBAND OR WIFE:

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

16. SOCIAL SECURITY NO.:

17. INFORMANT: John Ed. Cox Address: 1375 Temple

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) Status Epilepticus — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs.

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

DUE TO (b)

DUE TO (c) Grand Mal Epilepsy 353.1 — 4 yrs.

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 ☐ 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 Aug. 22, 1955, to Jan. 22, 1959 and last saw her/him alive on Jan. 22, 1959. Death occurred at 9:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John W. Beckham, M.D.

22b. ADDRESS: 5800 Arsenal

22c. DATE SIGNED: 1/23/59

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

23b. DATE: 29 Jan. 1959

23c. NAME OF CEMETERY OR CREMATORY: Washington Park.

23d. LOCATION (City, town, or county) (State): St. Louis Co. Mo.

24. FUNERAL DIRECTOR: Reliable Funeral Sys. ADDRESS: 1389 N. Union

25. DATE RECD. BY LOCAL REG.: JAN 26 '59

26. REGISTRAR'S SIGNATURE: J. Earl Smith M.D.

(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 John K Cunningham

Licensed Embalmer No. 4476

P. O. Address 2405 Marca

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.