Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

59-003568
STATE FILE NUMBER 2 657

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

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION: Homer G. Phillips — Length of stay in Ib

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): 2219 3210 Lawton — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Samuel Middle: Last: Terry

4. DATE OF DEATH: Month January Day 18 Year 59

5. SEX: Male 2
6. COLOR OR RACE: Negro
7. MARITAL STATUS: MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐
8. DATE OF BIRTH: Aug. 29, 1895
9. AGE (In years last birthday): 63 — IF UNDER 1 YEAR: Months 4 Days 20 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Merchant
10b. KIND OF BUSINESS OR INDUSTRY: Own Business
11. BIRTHPLACE (City and state or country): Crystal Spring, Miss.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: George Terry
13b. MOTHER'S MAIDEN NAME: Elizabeth Sandford
14. NAME OF HUSBAND OR WIFE: Emma Terry

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.: Unk.
17. INFORMANT: Callie Wilmer Address: 3210 Lawton

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): Subdural Hematoma — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): E902.7 45
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. Item 20b. injury in PART II of Item 18 suffered in fall from chair 1 floor in bathroom at Homer G. Phillips Hospital on ~~December~~ January 16, 1959
20c. TIME OF INJURY: Hour a.m. p.m. Month Day Year 1/18/59 ~~12-19-58~~ ~~12-19-58~~
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.): 113 Hosp
20f. CITY, TOWN, OR LOCATION: St Louis COUNTY: STATE: Mo.

21. I attended the deceased from ..... to ..... and last saw her/him alive on .....
Death occurred at 7:00 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Catherine E. Nyle (Degree or Title): 3
22b. ADDRESS: 1328 Clara
22c. DATE SIGNED: 1/20/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 1-26-1959
23c. NAME OF CEMETERY OR CREMATORY: Greenwood
23d. LOCATION (City, town, or county) (State): St. Louis County, Mo.

24. FUNERAL DIRECTOR: Wm. Smith ADDRESS: 4019 Washington
25. DATE RECD. BY LOCAL REG.: JAN 20 '59
26. REGISTRAR'S SIGNATURE: J. Carl Smith MD MDB

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF Coroner 3-11-59

All diseases in Part I must be causally related

USE ONLY BLACK INK OR RIBBON. PRINT NEATLY. DO NOT FOLD.

## 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 .....

Licensed Embalmer No. 4371

P. O. Address St. Louis, M

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.