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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003612
STATE FILE NUMBER

FILED FEB 10 1959

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 928

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 (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 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: 3139 Laclede — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 22/5 3139 Laclede — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: James — Middle: — Last: Washington

4. DATE OF DEATH: Month 1 — Day 22 — Year 59

5. SEX: Male 2

6. COLOR OR RACE: Negro

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

8. DATE OF BIRTH: Unknown 9

9. AGE (In years last birthday): 67 — 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): Labor

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Louisianna

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

13a. FATHER'S NAME: Unknown

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE:

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

16. SOCIAL SECURITY NO.: 492-05-7030

17. INFORMANT — Address: Gussie Ledbetter, Meridian, Miss.

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) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH:
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Carcinoma of Pancreas. — undet.
DUE TO (c) 157 x
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 ☒ 2-

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 1-19-59, to 1-22-59 and last saw him alive on 1-22-59
Death occurred at 7:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE S. A. Fraser (Degree or title) M.D.

22b. ADDRESS: 2601 Whittier Street

22c. DATE SIGNED: 1-23-59

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

23b. DATE: 1/28/59

23c. NAME OF CEMETERY OR CREMATORY: Oakedale Cemetary

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

24. FUNERAL DIRECTOR — ADDRESS: Wm. Smith 4019 Washington Blvd.

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

26. REGISTRAR'S SIGNATURE: J. Carl Smith Jr. 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 F. A. Green

Licensed Embalmer No. 2963

P. O. Address 4214 Delman

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.