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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003613
STATE FILE NUMBER

FILED JAN 28 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 406

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 3142 Franklin — Length of stay in 1b
d. STREET ADDRESS (If outside, give location) 3142 Franklin — Reside on Farm Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOUR b. COUNTY
c. CITY OR TOWN St Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS 3142 Franklin — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Middle Last: Nathaniel Washington
4. DATE OF DEATH Month 1 Day 12 Year 59
5. SEX M 2
6. COLOR OR RACE C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐
8. DATE OF BIRTH Sept. 28 1894
9. AGE (In years last birthday) 64 — IF UNDER 1 YEAR Months 3 Days 14 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Little Rock 1
12. CITIZEN OF WHAT COUNTRY? Ark.
13a. FATHER'S NAME Henry Wasington
13b. MOTHER'S MAIDEN NAME Callie Wheeler
14. NAME OF HUSBAND OR WIFE Mamie Washington
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.
17. INFORMANT Hazel Keaton — Address 3142 Franklin

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Apoplexy — 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) 334X
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 _____, to _____ and last saw her/him alive on _____
Death occurred at 845 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature] Deputy Coroner 3
22b. ADDRESS 1200 Clay
22c. DATE SIGNED 1/13/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 1-19-59
23c. NAME OF CEMETERY OR CREMATORY Natl. Cemetery
23d. LOCATION (City, town, or county) Jefferson Bk. (State) Mo.

24. FUNERAL DIRECTOR A.F. Walton — ADDRESS 2707 Stoddard
25. DATE RECD. BY LOCAL REG. JAN 13'59
26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. M.J.B.

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

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 W. Chandler Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Alde

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.