

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006971

STATE FILE NUMBER

2 1771

FILED MAR 10 1959

Registration District No. _____ Primary Registration District No. _____

Registrar's No. _____

300
-57
72

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2929th Thomas		Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 2929 Thomas	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					

3. NAME OF DECEASED (Type or print) First Katie Middle _____ Last Casesy			4. DATE OF DEATH Month Feb Day 17 Year 1959		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown Oct 80	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Tenn		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Jerry Moore		13b. MOTHER'S MAIDEN NAME Mary Kregg		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) no	16. SOCIAL SECURITY NO.	17. INFORMANT Lee Moore 2929 Thomas	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE HEART DISEASE		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) _____	
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	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.		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from **JAN. 1957**, to **FEB. 1959** and last saw her alive on **FEB. 15, 1959**
Death occurred at **2:30 A** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Clavis H. Beene M.D.	22b. ADDRESS 2625 OLIVE ST	22c. DATE SIGNED 2/7/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Feb 23/59	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cem	23d. LOCATION (City, town, or county) (State) St. Louis County MO
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24. FUNERAL DIRECTOR F. A. Green	ADDRESS 4214 Delmar	25. DATE RECD. BY LOCAL REG. FEB 19 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

m. c.

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 *G. A. Green*

Licensed Embalmer No. ²⁹⁶³ ₄₂₁₄

P. O. Address

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.