

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007046

State File No.

2 1322

Registrar's No.

FILED MAR 2 1959

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b>				c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis State Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>5400 Arsenal St.,</b>			
3. NAME OF DECEASED (Type or Print)		a. (First) <b>EDWARD</b>		b. (Middle) <b>BRUCE</b>		c. (Last) <b>DOUGLAS</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced 3</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 3, 1959</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>formerly: Laborer</b>		8. DATE OF BIRTH <b>July 1, 1898</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR Hours Days IF UNDER 1 RES. Hour Min. <b>60</b>	
11a. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13a. FATHER'S NAME <b>Charles A. Douglas</b>		13b. MOTHER'S MAIDEN NAME <b>Louivinia (Callaway)</b>		14. NAME OF HUSBAND OR WIFE <b>Modesta</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Harry Douglas 4319 Enright</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, aneurysm, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Thrombosis</b>					
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cerebral Arteriosclerosis</b>					
		DUE TO (c) <b>Generalized Arteriosclerosis</b>					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Schizophrenic Reaction - 332X</b>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>Hebephrenic type.</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR			
22. I hereby certify that I attended the deceased from <b>Sept. 9, 1935</b> to <b>Feb. 3, 1959</b> that I last saw the deceased alive on <b>Feb. 3, 1959</b> , and that death occurred at <b>3:00 p.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>L. Hofstatter, M.D.</b>				23b. ADDRESS <b>5400 Arsenal St.</b>		23c. DATE SIGNED <b>2-4-59</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>2/7/59</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>FEB 6 '59</b>		REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Charles J. Gates 4107 Finney</b>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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. 1589

P. O. Address 4107 Fern

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.