

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007269
STATE FILE NUMBER 1333

FILED MAR 2 1959		Registration District No. _____		Primary Registration District No. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY _____			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis</u> Inside Limits Yes ☒ No ☐				c. CITY OR TOWN <u>St Louis</u> Inside Limits Yes ☒ No ☐			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Inn on Mt. St. Helens</u> Length of stay in 1b _____				d. STREET ADDRESS <u>2623 Delmar</u> (If outside, give location) Reside on Farm Yes ☐ No ☒			
3. NAME OF DECEASED (Type or print) <u>Bessie . A. James</u> First Middle Last				4. DATE OF DEATH <u>2-4-59</u> Month Day Year			
5. SEX <u>P</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐		8. DATE OF BIRTH <u>3 16 1912</u>	
9. AGE (In years, last birthday) <u>46</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (City and state or country) <u>Tenn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Richard Allen</u>		13b. MOTHER'S MAIDEN NAME <u>Lillie Foster</u>		14. NAME OF HUSBAND OR WIFE <u>Unknown</u>			
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. <u>49428 3856</u>		17. INFORMANT Address <u>James D. Austin 5175 Cabonne</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Emphysema</u> Generalized Sclerosis 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)						INTERVAL BETWEEN ONSET AND DEATH <u>527.1</u>	
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 _____ Month, Day, Year _____ a.m. _____ p.m. _____							
20d. INJURY OCCURRED WHILE AT ☐ 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 alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>James D. Austin</u> (Do not write)		22b. ADDRESS <u>1300 Claes</u>		22c. DATE SIGNED <u>2/7/59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>2/7/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Louis</u>		23d. LOCATION (City, town, or county) (State) <u>East St. Louis Ill</u>	
24. FUNERAL DIRECTOR <u>A. H. Brakes</u>		ADDRESS <u>3506 Franklin</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 7-1959</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MS
FEB 21 1937

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 *Leroy W. Barnister*

Licensed Embalmer No. *4523*

P. O. Address *2616 N. Ham*

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.