

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007271

STATE FILE NUMBER

2 1518

FILED MAR 9 1959 Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Webster Groves 4597
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 201 Sherman
3. NAME OF DECEASED (Type or print) First Middle Last ROLLIE NMN JAMES			4. DATE OF DEATH Month Day Year FEBRUARY 10, 1959
5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-17-1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY City, Webster Gr.	11. BIRTHPLACE (City and state or country) St. Louis, Mo. c
13a. FATHER'S NAME Austin James		13b. MOTHER'S MAIDEN NAME UNK.	14. NAME OF HUSBAND OR WIFE Ruth James
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. 486-18-5660	17. INFORMANT Address Mrs. Ruth James 201 Sherman
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STASIS PNEUMONIA - BRONCHOPNEUMONIA, BILATERAL DUE TO (b) CEREBRAL VASCULAR ACCIDENT DUE TO (c) HYPERTENSION 331X 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 3 DAYS SEVERAL MONTHS SEVERAL YEARS
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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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
21. I attended the deceased from JAN. 23, 1959, to FEB. 10, 1959 and last saw her alive on FEB. 10, 1959 Death occurred at 4:00 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) F.R. Bradley M. D.		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 2/11/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-15-59	23c. NAME OF CEMETERY OR CREMATORY Father Dickson	23d. LOCATION (City, town, or county) (State) Crestwood St. Louis Co., Mo.
24. FUNERAL DIRECTOR ADDRESS Lewis Funeral Home 22 Euclid Ave		25. DATE RECD. BY LOCAL REG. FEB 13 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M. D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 James A. Carter

Licensed Embalmer No. 4681
P. O. Address For No

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.