

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007315

STATE FILE NUMBER
Registrar No. 1583

FILED MAR 2 1959

Registration District No. Primary Registration District No. Registrar No.

300
1-57
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. City Hospital		d. STREET ADDRESS 2908 Chouteau	
3. NAME OF DECEASED (Type or print) First Middle Last Shirley RAY KING		4. DATE OF DEATH Feb 12 1959 2 12 59	
5. SEX FEMALE	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and state or country) ST. LOUIS
13a. FATHER'S NAME John Galloway		13b. MOTHER'S MAIDEN NAME FRANKIE KING	14. NAME OF HUSBAND OR WIFE NONE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or address of service) NO NO NO		16. SOCIAL SECURITY NO. NO	17. INFORMANT LOLA KING 2908 Chouteau
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity Hydrocephalus 344.1 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
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.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 1044 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Calvin E. King		22b. ADDRESS 1200 Olive	
22c. DATE SIGNED 2/14/59		22d. (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 2-14-59	23c. NAME OF CEMETERY OR CREMATORY Father dieulson	23d. LOCATION (City, town, or county) St. Louis County
24. FUNERAL DIRECTOR S. J. Watson 2769 Chouteau		25. DATE RECD. BY LOCAL REG. FEB 14 '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.

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

Wasnt Embalmed

Licensed Embalmer No.....

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.