

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007379

STATE FILE NUMBER

2-1448

Registration District No.

Primary Registration District No.

Registrar No.

FILED FEB 26 1959

300  
-57  
8  
592  
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>1310 Biddle</b>
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <b>Ruth</b>	Middle	Last <b>Logan</b>	4. DATE OF DEATH	Month <b>1</b>	Day <b>26</b>	Year <b>59</b>
-------------------------------------	-------------------	--------	-------------------	------------------	----------------	---------------	----------------

5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-15-1885</b>	9. AGE (In years last birthday) <b>73</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
-------------------------	----------------------------------	---	---------------------------------------	--	---------------------------	--------------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Unknown</b>	12. CITIZEN OF WHAT COUNTRY? <b>unknown</b>
---	-----------------------------------	--	--

13a. FATHER'S NAME <b>unknown</b>	13b. MOTHER'S MAIDEN NAME <b>unknown</b>	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)	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mrs. Mary Jett</i>	Address <b>R.R.L. 2601 Whittier St.</b>
---	-------------------------	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>	INTERVAL BETWEEN ONSET AND DEATH <b>undet.</b>
--	---

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) \_\_\_\_\_

DUE TO (c) \_\_\_\_\_

332+

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Gangrene, Both Feet</b> <b>Arteriosclerosis, Generalized</b>	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
---	--	--	------------------------------	--------	-------

21. I attended the deceased from <b>12-17-58</b> to <b>1-26-59</b> and last saw her alive on <b>1-26-59</b> Death occurred at <b>5:45</b> <b>P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <i>F.O. Richards</i> (Degree or title) <b>, M.D.</b>	22b. ADDRESS <b>2601 Whittier Street</b>	22c. DATE SIGNED <b>1-28-59</b>
--	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>2-28-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
---	-----------------------------	---	--

24. FUNERAL DIRECTOR <b>Rowland Aker Mortuary Service</b> 4104 Manchester Ave. St. Louis 10, Mo.	25. DATE RECD. BY LOCAL REG. <b>FEB 1 1959</b>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
---	---	--

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 .....

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.