

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007382  
STATE FILE NUMBER  
2002  
Registrar's No.

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

**FILED MAR 10 1959**

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>		c. CITY OR TOWN <b>St. Louis</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		d. STREET ADDRESS <b>4300 St. Ferdinand Ave.</b>	
Length of stay in lb <b>19 Years</b>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Minnie Long</b>			4. DATE OF DEATH Month Day Year <b>2 - 24 - 1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>3 Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 10, 1905</b>
9. AGE (In years last birthday) <b>53</b>	IF UNDER 1 YEAR Months Days <b>10 14</b>	IF UNDER 24 HRS. Hours Min. -----	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) <b>Murray, Kentucky</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Dave Haynes</b>	
13b. MOTHER'S MAIDEN NAME <b>Ida Wilson</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) <b>No</b>		16. SOCIAL SECURITY NO. <b>UNK</b>	17. INFORMANT Address <b>Martha Richardson 4357 No. Market 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>Ruptured Esophageal Varices</b> DUE TO (b) <b>Cerebral Sclerosis</b> DUE TO (c) <b>Chronic Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>420.1</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 WORK 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 <b>St. Louis</b>		COUNTY STATE <b>Mo.</b>	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <b>6:45 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Agnes Quinn</i> Occupation <b>Owner</b>		22b. ADDRESS <b>1300 Clark</b>	
22c. DATE SIGNED <b>2/25/59</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
23b. DATE <b>Mar. 2, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	
23d. LOCATION (City, town, or county) <b>St. Louis Co., Mo.</b>		24. FUNERAL DIRECTOR ADDRESS <b>Jas. H. Randle &amp; Son 3133 Bell Ave.</b>	
25. DATE RECD. BY LOCAL REG. <b>FEB 25 '59</b>		26. REGISTRAR'S SIGNATURE <i>Loard Smith, M.D.</i>	

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Ethel K. Harris* .....

Licensed Embalmer No. *4458* .....  
P. O. Address *4181 Washington* .....

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.