

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007460  
STATE FILE NUMBER  
2 1101  
Registrar's No.

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

**1. PLACE OF DEATH**  
a. COUNTY \_\_\_\_\_  
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis Inside Limits Yes  No   
c. FULL NAME OF (IF NOT in hospital, give location). HOSPITAL OR INSTITUTION Homer & Phillips Length of stay in 1b \_\_\_\_\_

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)  
a. STATE Missouri b. COUNTY \_\_\_\_\_  
c. CITY OR TOWN St Louis Inside Limits Yes  No   
d. STREET ADDRESS (If outside, give location) 1221 Clara ave Reside on Farm Yes  No

**3. NAME OF DECEASED** (Type or print) First Lucy Middle \_\_\_\_\_ Last Miner  
4. DATE OF DEATH Month 1 Day 29 Year 1959

5. SEX Female 6. COLOR OR RACE Negro. 7. MARRIED  NEVER MARRIED  WIDOWED  2 DIVORCED  8. DATE OF BIRTH 12-23-1909 9. AGE (In years last birthday) 49 IF UNDER 1 YEAR Months \_\_\_\_\_ Days \_\_\_\_\_ IF UNDER 24 HRS. Hours \_\_\_\_\_ Min. \_\_\_\_\_

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid 10b. KIND OF BUSINESS OR INDUSTRY \_\_\_\_\_ 11. BIRTHPLACE (City and state or country) Brisko, Ark 12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME Wm. Kirkpatrick 13b. MOTHER'S MAIDEN NAME unknown 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. 7:9 17. INFORMANT Melba Brown Address 1221 Clara ave

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) DEATH FROM MENSTRUATION  
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) HYPERTENSION  
DUE TO (c) 331X  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) \_\_\_\_\_

19. WAS AUTOPSY PERFORMED? YES  NO

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 \_\_\_\_\_ a.m. \_\_\_\_\_ p.m. Month, Day, Year \_\_\_\_\_

20d. INJURY OCCURRED WHILE AT WORK  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 1/13/59 to 1/29/59 and last saw her/him alive on 1/29/59  
Death occurred at 3:25 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Clara H. Beach, D.O. 22b. ADDRESS 2605 Olive St 22c. DATE SIGNED 1/30/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 2-2-1959 23c. NAME OF CEMETERY OR CREMATORY Greenwood 23d. LOCATION (City, town, or county) (State) St Louis MO

24. FUNERAL DIRECTOR ADDRESS Boyd Funeral Home 3704 Finney 25. DATE RECD. BY LOCAL REG. JAN 31 1959 26. REGISTRAR'S SIGNATURE Paul Smith, M.D.

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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 *M. Claude Gordon* .....

Licensed Embalmer No. *3489* .....  
P. O. Address *4575th St* .....

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.