Health, Welfare Public Service

300 -57

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007659
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1680

FILED MAR 10 1959

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 3 D.O.A. Phillips — Length of stay in Hospital: Life

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 [X] No [ ]
d. STREET ADDRESS (If outside, give location): 1733a Lovejoy Lane — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: QUEENY Middle: Last: SMITH

4. DATE OF DEATH: Month Day Year: Feb. 14, 1959

5. SEX: Female 3
6. COLOR OR RACE: Negro
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] 0 DIVORCED [ ]
8. DATE OF BIRTH: Feb. 3, 1880
9. AGE (In years if last birthday): 79 — 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): None
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (City and state or country): 0 St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME: ?
13b. MOTHER'S MAIDEN NAME: Emmaline McKensie
14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mercer Smith Address: 4544 Aldine Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 42 D.C
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 [X] 2

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 _____ 19 _____ and last saw her/him alive on _____
Death occurred at 1000 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Patrick C. Taylor (Degree or title) Coroner
22b. ADDRESS: 1300 Clark
22c. DATE SIGNED: 2.17.59.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 2/18/59
23c. NAME OF CEMETERY OR CREMATORY: Washington Park Cem.
23d. LOCATION (City, town, or county) (State): St. Louis County, Mo.

24. FUNERAL DIRECTOR: Charles J. Gates ADDRESS: 4107 Finney
25. DATE RECD. BY LOCAL REG.: FEB 17 59
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Guyton Swan

Licensed Embalmer No. 4580

P. O. Address 4107 Finney Aven

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.