

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010730

STATE FILE NUMBER 2-2188
Registration District No. Primary Registration District No. Registrar's No.

FILED MAR 17 1959

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
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 Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 4156 Enright	

3. NAME OF DECEASED (Type or print) First Middle Last Louis Boxx			4. DATE OF DEATH Month Day Year 2 27 59		
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 19 1913	9. AGE (In years last birthday) 45	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	10b. KIND OF BUSINESS OR INDUSTRY RETIRED	11. BIRTHPLACE (City and state or country) DIXSON TENN	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME WARREN BOXX	13b. MOTHER'S MAIDEN NAME JULIA BOXX	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. NO	17. INFORMANT Address NORA BRANDON 4156 ENRIGHT
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration & Asphyxia		INTERVAL BETWEEN ONSET AND DEATH undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerosis - Thrombosis, Femoral Aneurysm		19. WAS AUTOPSY PERFORMED? 1 YES <input checked="" type="checkbox"/> NO <input 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 Month, Day, Year a.m. p.m.		
20d. INJURY OCCURRED WHILE AT <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 9217 46

21. I attended the deceased from 2-8-59 to 2-27-59 and last saw ^{him} alive on 2-27-59 Death occurred at 5:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Name or title) F.O. Richardson MD.	22b. ADDRESS 2601 Whittier Street	22c. DATE SIGNED 3-2-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-5-59	23c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK	23d. LOCATION (City, town, or county) (State) St. Louis Co MO.
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24. FUNERAL DIRECTOR ADDRESS S.T. WATSON 2769 Chouteau	25. DATE RECD. BY LOCAL REG. MAR 3 '59	26. REGISTRAR'S SIGNATURE Loan 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 *Fuller E. Culkin*

Licensed Embalmer No. *198*
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.