

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011037

STATE FILE NUMBER

2340

MAR 20 1959

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

300
1-57
8
696
0

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 Community Hospital		d. STREET ADDRESS (If outside, give location) 5203 Miner va	

3. NAME OF DECEASED (Type or print) First Levarde Middle Last Ike			4. DATE OF DEATH Month 3 Day 4 Year 59			
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-13-1905	9. AGE (In years (log birthday)) 53	FUNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Macon, Mississippi	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Carl Sanders	13b. MOTHER'S MAIDEN NAME Louise McCleon	14. NAME OF HUSBAND OR WIFE Robert B. Ike
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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. none	17. INFORMANT Robert B. Ike	Address 5203 Minerva Avenue
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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) Accl. Sunstroke		INTERVAL BETWEEN ONSET AND DEATH Feb 8/59
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hot Weather DUE TO (c) 163X		
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 <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.)
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20c. TIME OF INJURY Hour 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
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21. I attended the deceased from Feb 8/1959 and last saw her March 4, 1959 Death occurred at 3:15 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE Haskell M.D.	(Degree or title)	22b. ADDRESS 1303N Kingshighway	22c. DATE SIGNED 3-5-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 3-9-59	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
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24. FUNERAL DIRECTOR Russell Und., Co.	ADDRESS 2732 Pine Street	25. DATE RECD. BY LOCAL REG. MAR 6 '59	26. REGISTRAR'S SIGNATURE Carl Smith. M.D.
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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 *James A Carter*

Licensed Embalmer No. *4618*

P. O. Address *St. Louis*

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.