

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011397
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registration No. **8-2147**

1. PLACE OF DEATH
a. COUNTY _____ 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **MO.** b. COUNTY _____

b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits
OR **St. Louis** Yes No
TOWN

c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb
HOSPITAL OR **Homer Phillips Hosp.**
INSTITUTION

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year
(Type or print) **John Sinkfield** **2-27-59**

5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED
Male 2 Col. WIDOWED DIVORCED
8. DATE OF BIRTH 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.
May 15-1914 **44** Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done, if of working kind) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (City and state or country) 12. CITIZEN OF WHAT COUNTRY?
Foreign laborer **Wabash R.R.** **Miss!** **USA**

13a. FATHER'S NAME 13b. MOTHER'S MAIDEN NAME 14. NAME OF HUSBAND OR WIFE
Unknown **Unknown** **Mamie Sinkfield**

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. 17. INFORMANT Address
no **709-057-591** **Mamie Sinkfield-2730 Delmar**

18. CAUSE OF DEATH (Enter only one cause possible for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **Cerebral Hemorrhage**
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 (c) **331x**
INTERVAL BETWEEN ONSET AND DEATH
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 Month, Day, Year
a.m. p.m.

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

22a. SIGNATURE (Name or title) 22b. ADDRESS 22c. DATE SIGNED
John Sinkfield **1300 Clark** **3/2/59**

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) (State)
Removal **3-6-59** **Washington Park Cemetery** **St. Louis Co., Mo.**

24. FUNERAL DIRECTOR ADDRESS 25. DATE RECD. BY LOCAL REG. 26. REGISTRARS SIGNATURE
A. L. Beal Und.-4303 Delmar **MAR 2 '59** **Earl Smith. M.D.**

300
1-57
28
194
0

Director, coroner, etc. must use only standard nomenclature in item 10. No symptoms will be entered. 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 A. D. Reichen

Licensed Embalmer No. 2911

P. O. Address 2625 51

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.