

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012335

STATE FILE NUMBER

LED APR 27 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 396

300
1-57

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>City of St. Louis</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i> 2009 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>State Hosp #2</i>		Length of stay in lb <i>79 years</i>	d. STREET ADDRESS (If outside, give location) <i>City Sanatorium</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>ORA</i> Middle <i>none</i> Last <i>BALES</i>			4. DATE OF DEATH Month <i>April</i> Day <i>17</i> Year <i>1959</i>		
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>September 20, 1908</i>	9. AGE (In years at birthday) <i>55</i>	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) <i>Laborer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>	11. BIRTHPLACE (City and state or country) <i>Bethany, Illinois</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
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13a. FATHER'S NAME <i>Unknown</i>	13b. MOTHER'S MAIDEN NAME <i>Lena Redmond</i>	14. NAME OF HUSBAND OR WIFE <i>None</i>
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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) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>State Hosp #2, St. Joseph, Mo.</i> Address
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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) <i>Pulmonary Edema</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Intracranial hemorrhage</i>		<i>unknown</i>
	DUE TO (c) <i>Epilepsy</i>		<i>25 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>3533</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>2</i>	

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 <i>4-17-1959</i> to <i>4-17-59</i> and last saw him alive on <i>4-17-59</i> Death occurred at <i>11.00 p.m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <i>Mohammed John M-B.</i>	22b. ADDRESS <i>State Hosp #2 St. Joseph, Mo.</i>	22c. DATE SIGNED <i>4-17-59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>April 21, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Kirkville College of Osteopathy</i>	23d. LOCATION (City, town, or county) (State) <i>Kirkville, Mo.</i>
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24. FUNERAL DIRECTOR <i>Clark Funeral Home 120 Illinois Ave.</i>	25. DATE RECD. BY LOCAL REG. <i>April 21, 1959</i>	26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Stodell</i>
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All diseases in Part I must be causally related.

MEDICAL CERTIFICATION USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. Mohammed Taher

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 *Alvin P. Bazar*

Licensed Embalmer No. *4795*
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.