

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-014615

FILED APR 24 1959

Registration District No.

Primary Registration District No.

STATE FILE NUMBER

2936

300  
-57

75

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Route City Hospital</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>5575 Maple Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Lonnie</b> Last <b>Alexander</b>			4. DATE OF DEATH Month <b>March</b> Day <b>21</b> Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 23, 1927</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector - Health Dep't.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City of St. Louis</b>	9. AGE (In years last birthday) <b>31</b> F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
11. BIRTHPLACE (City and state or country) <b>Parkin, Arkansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13a. FATHER'S NAME <b>William Alexander</b>		13b. MOTHER'S MAIDEN NAME <b>Lenore Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Beatrice</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT Address <b>Beatrice Alexander, 5575 Maple Ave.</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cyanide Intoxication.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>E 971.8</b>
DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS RELATING TO DEATH <b>Following inhalation of calcium cyanide in enclosed space of truck in garage at #9 10. Leffingwell, exact time unknown, but or about 3:20 PM March 20, 1959</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (For nature of injury, see PART I of form 18) <b>enclosed space of truck in garage at #9 10. Leffingwell, exact time unknown, but or about 3:20 PM March 20, 1959</b>		
20c. TIME OF INJURY Hour <b>3:20</b> Month, Day, Year <b>March 20, 1959</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Garage</b>	20f. CITY, TOWN, OR LOCATION <b>St. Louis Mo.</b>
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <b>1110 A</b> m on the date stated above; and to the best of my knowledge from the causes stated.			
22a. SIGNATURE <b>Patrick Taylor Coroner</b>		22b. ADDRESS <b>1300 Clark</b>	22c. DATE SIGNED <b>3.23.59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>3-24-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>	23d. LOCATION (City, town, or county) (State) <b>Manila, Arkansas</b>

24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 23 '59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
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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 *Elmo R. Sadwell* .....

Licensed Embalmer No. *4077* .....  
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.