

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-014716

STATE FILE NUMBER

FILED MAY 11 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **3753**

300  
-57  
92  
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D.O.A. Homer Phillips Hosp</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>5035 Maple</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Oscar</b> Middle Last <b>BOLTON</b>			4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</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>June 20, 1928</b>	9. AGE (In years birth day) <b>30</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Chicago, Ill.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Oscar Bolton, Sr.</b>	13b. MOTHER'S MAIDEN NAME <b>Clara Dougherty</b>	14. NAME OF HUSBAND OR WIFE <b>Laura Bolton</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give year or dates of service) <b>Yes WW-2</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Laura Bolton, 5035 Maple Avenue</b> Address
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18. CAUSE OF DEATH (Enter only one cause. Give line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Traumatic Extensive Subdural Hemorrhage (Fractured Skull)</b>		INTERVAL BETWEEN ONSET AND DEATH
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 (e.g., chronic disease, etc.) <b>Suffered from diabetes</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. HOW INJURY OCCURRED. (Enter number of injury in PART I or PART II of item 18.) <b>William Scott in car at 4059 Aldine Ave., about 400am.</b>
20c. TIME OF INJURY Hour <b>4:00</b> a.m. Month <b>April</b> Day <b>13</b> Year <b>1959</b>	<b>E983+</b>

20d. INJURY OCCURRED WHILE AT WORK <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.) <b>Home</b>	20f. CITY, TOWN, OR LOCATION <b>St Louis Mo</b>	COUNTY STATE
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21. I attended the deceased from **4:30 A** to \_\_\_\_\_ and last saw her alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Regina Turner</b>	22b. ADDRESS <b>1300 Clark</b>	22c. DATE SIGNED <b>4/13/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>4/16/59</b>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <b>Detroit, Michigan</b>
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24. FUNERAL DIRECTOR <b>Cunningham &amp; Moore, 2405 Marcus</b>	25. DATE RECD. BY LOCAL REG. <b>APR 16 '59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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 *John K. Cunningham* .....

Licensed Embalmer No. *4476* .....  
P. O. Address *2405 Main* .....

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.