

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-014878

STATE FILE NUMBER

2 3301

APR 20 1959 Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Marys Infirmary</u>		Length of stay in lb <u>30 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>4339 Cote Brill.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Alberta.</u> Middle <u>S.</u> Last <u>DENNIS</u>		4. DATE OF DEATH Month <u>3-</u> Day <u>31-</u> Year <u>59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1901</u> <u>October 28,</u> <u>57</u>
9. AGE (In years last birthday)		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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	11. BIRTHPLACE (City and state or country) <u>Warren, Arkansas</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Isiah Sanford</u>	
13b. MOTHER'S MAIDEN NAME <u>Viola Butler</u>		14. NAME OF HUSBAND OR WIFE <u>Moses Dennis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>498-16-5151</u>	
17. INFORMANT Address <u>Moses Dennis 4339 Cote Brillante</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> Conditions, if any, which gave rise to above cause (c), stating the underlying cause last. } DUE TO (b) <u>Hodgkin's Disease</u> DUE TO (c) <u>201X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>5 yrs.</u>		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.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ 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	
21. I attended the deceased from <u>NOV. 12, 1954</u> , to <u>MAR. 31, 1959</u> and last saw her alive on <u>3-31-59</u> . Death occurred at <u>8:50 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>William C. Bontempo, M.D.</u>		22b. ADDRESS <u>2917 ST. LOUIS AVE</u>	
22c. DATE SIGNED <u>3-31-59</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>4/6/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park Cem.</u>	
23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>		24. FUNERAL DIRECTOR <u>Gates Funera Home 4107 Finney</u>	
25. DATE RECD. BY LOCAL REG. <u>APR 2 '59</u>		26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u> <u>mdb</u>	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300  
1-57  
3  
193  
0

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 ..... *Gupton, Susan*

Licensed Embalmer No. *4580*

P. O. Address *4107 Jun*

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.