

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014919
STATE FILE NUMBER
Registrar 2 4275

FILED MAY 14 1959 Registration District No. Primary Registration District No. Registrar 2 4275

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP		d. STREET ADDRESS (If outside, give location) 5746 Enright Ave.	

3. NAME OF DECEASED (Type or print) First JAMES Middle EUGENE Last DRURY			4. DATE OF DEATH Month APRIL Day 30 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 6, 1871	9. AGE (In years last birthday) 87	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chinaware Salesman (ret)		10b. KIND OF BUSINESS OR INDUSTRY Chinaware		11. BIRTHPLACE (City and state or country) Kentucky	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Elizabeth --	
14. NAME OF HUSBAND OR WIFE Anna M. Drury		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 498-09-9523A	
17. INFORMANT Mr. Lotus O. Drury		Address 8705 Kendale Drive			

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><i>Proterion Myocardial Infarction</i></u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u><i>Atherosclerotic Heart Disease</i></u>		
DUE TO (c) <u><i>420.0</i></u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		

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 a.m. Month, Day, Year 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 St. Louis Co., Mo.	COUNTY	STATE
21. I attended the deceased from <u><i>4/24/59</i></u> to <u><i>4/30/59</i></u> and last saw ^{her} him alive on <u><i>4/30/59</i></u> Death occurred at <u><i>12:10 A.M.</i></u> m on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <i>Loan Smith, M.D.</i> (Degree or title)	22b. ADDRESS 1515 LAFAYETTE AVE.	22c. DATE SIGNED 4/30/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 5-2-59	23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
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24. FUNERAL DIRECTOR Drehmann-Harral	ADDRESS 1905 Union	25. DATE RECD. BY LOCAL REG. MAY 1 '59	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Warren A. Carver*

Licensed Embalmer No. *3534*

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.