

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014934

STATE FILE NUMBER
2 3658

FILED MAY 6 1959 Registration District No. Primary Registration District No. Registrar No.

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1-57
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION Homer Phillips Hosp.		d. STREET ADDRESS 4354 Enright	
(If NOT in hospital, give location) Hosp. of stay in lb		(If outside, give location)	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last Benne Parks Easter			4. DATE OF DEATH Month Day Year 4 10 59			
5. SEX Female 3	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-30-04	9. AGE (In years last birthday) 54	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Music teacher		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Marlin, Texas		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Benjamin Parks		13b. MOTHER'S MAIDEN NAME Louvanna Stamps		14. NAME OF HUSBAND OR WIFE Joseph Easter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Dr. Joseph Easter-4354 Enright	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) 331X		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 _____ to _____ and last saw her alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Begin with name) Paul J. Simon Coroner 3		22b. ADDRESS 1300 Clark		22c. DATE SIGNED 4/13/59	
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23a. BURIAL, CREMATION, REMOVAL Removal <input checked="" type="checkbox"/>		23b. DATE 4-14-59		23c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.		23d. LOCATION (City, town, or county) (State) Berkeley Mo.	
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24. FUNERAL DIRECTOR ADDRESS A.L. Real Und. Co.-4303 Delmar		25. DATE RECD. BY LOCAL REG. APR 14 '59		26. REGISTRAR'S SIGNATURE Paul Smith, M.D.	
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Locater, coroner, etc. must use only standard nomenclature in item 10. The symptoms with no tabular. All diseases in Part I must be causally related.

m.s.g

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 *A. D. Richardson*

Licensed Embalmer No. *2928*
P. O. Address *City*

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.