

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014988

STATE FILE NUMBER
2 3245

REG APR 20 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

300
1-57
7
72
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chronic Hosp.</u>		Length of stay in lb <u>3 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>1104 Hadley</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle Last <u>Garnett</u>			4. DATE OF DEATH Month <u>3</u> Day <u>17</u> Year <u>59</u>		
---------------------------------------------------------------------------------------	--	--	-----------------------------------------------------------------	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>3 col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-26-1900</u>	9. AGE (In years last birthday) <u>58</u>	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>NONE</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Miss.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
------------------------------------------------------------------------------------------------------------	-----------------------------------	------------------------------------------------------------	--------------------------------------------

13a. FATHER'S NAME <u>UNKNOWN</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>--</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>NONE</u>	17. INFORMANT <u>Hospital Records</u> Address <u>5600 Arsenal</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>Bilateral Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<u>491X</u>
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 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 _____ a.m. _____ p.m.	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.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
---------------------------------------------------	--------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	----------------------------------------------------------

21. I attended the deceased from <u>3-20-56</u> to <u>3-17-59</u> and last saw her/him alive on <u>3-17-59</u> Death occurred at <u>10:00 a.m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>John W. Beckham, M.D.</u>	22b. ADDRESS <u>5800 Arsenal</u>	22c. DATE SIGNED <u>3/17/59</u>
------------------------------------------------------------------	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-31-59</u>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
-------------------------------------------------------------	-----------	---------------------------------------------------------------	------------------------------------------------------------------------

24. FUNERAL DIRECTOR <u>Rowland Aker Mortuary Service</u> ADDRESS <u>4104 Manchester Ave. St. Louis 10, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>MAR 31 '59</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>
--------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------	------------------------------------------------------

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

vector, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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

Licensed Embalmer No.....

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.