

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015201

STATE FILING NUMBER  
Registration No. 4214

MAY 12 1959

Registration District No. Primary Registration District No.

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>Chronic Hosp.</b>		Length of stay in lb <b>4 yrs. 10</b>	d. STREET ADDRESS (If outside, give location) <b>5800 Arsenal St.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Daisy</b> Middle Last <b>Jones</b>			4. DATE OF DEATH Month <b>4</b> Day <b>16</b> Year <b>59</b>	
--	--	--	---	--

5. SEX <b>female</b>	6. COLOR OR RACE <b>col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-26-1900</b>	9. AGE (In years last birthday) <b>59</b>	10. UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
-------------------------	---------------------------------	---	--------------------------------------	--	--	---------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Ark.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
--	-----------------------------------	---	--

13a. FATHER'S NAME <b>George Branch</b>	13b. MOTHER'S MAIDEN NAME <b>Mariah Cabbell</b>	14. NAME OF HUSBAND OR WIFE <b>--</b>
--	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>--</b>	17. INFORMANT Address <b>Hospital Records 5800 Arsenal St.</b>
---	--------------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovasc. Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c) <b>Generalized Arteriosclerosis</b>	<b>4 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Decubitus Ulcers - 2 yrs.</b>		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.) <b>449X</b>
---	---

20c. TIME OF INJURY Hour Month, Day, Year 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 <b>6-8-54</b> to <b>4-16-59</b> and last saw her alive on <b>4-16-59</b> Death occurred at <b>1:30 pm</b> on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <b>John W. Beckham, M.D.</b>	22b. ADDRESS <b>5800 Arsenal</b>	22c. DATE SIGNED <b>4/16/59</b>
--	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>4-30-59</b>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
---	-----------	---	--

24. FUNERAL DIRECTOR ADDRESS <b>Rowland Aker Mortuary Service 4104 Manchester Ave. St. Louis 10, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>APR 30 59</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>
---	--	--

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 .....

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.