

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015601

STATE FILE NUMBER

FILED APR 24 1959 Registration District No. _____ Primary Registration District No. _____ Registrar No. **3507**

300
-57
5
59-3
0

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN ST. LOUIS, MO. 221 SOBROADWAY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.			Length of stay in lb		d. STREET ADDRESS (If outside, give location) 221 SO. BROADWAY
3. NAME OF DECEASED (Type or print) First ERNEST Middle RICHARDS Last			4. DATE OF DEATH Month MARCH Day 16 Year 1959		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/28/85	9. AGE (In years at birthday) 73	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	11. BIRTHPLACE (City and state or country) UNKNOWN	12. CITIZEN OF WHAT COUNTRY? ???	
13a. FATHER'S NAME NOT KNOWN		13b. MOTHER'S MAIDEN NAME NOT KNOWN		14. NAME OF HUSBAND OR WIFE	
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. ??	17. INFORMANT Address ST. LOUIS CITY HOSP. #1.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary tuberculosis, activity unknown					INTERVAL BETWEEN ONSET AND DEATH unk.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 002X					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) malnutrition.					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 3/13/59 to 3/16/59 and last saw her/him alive on 3/16/59 Death occurred at 2:30 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Jean A. Chapman, MD (Signature or title)		22b. ADDRESS 1515 LAFAYETTE AVE		22c. DATE SIGNED 3/16/59	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 4-30-59	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
24. FUNERAL HOME Rowland Aker Mortuary Service 4104 Manchester Ave. St. Louis 10, Mo		25. DATE RECD. BY LOCAL REG. APR 9 '59		26. REGISTRAR'S SIGNATURE Roan Smith, M.D. mrb	

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.