

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015820

STATE FILE NUMBER

2 3413

FILED MAY 8 1959

Registration District No. Primary Registration District No.

Registrar's No.

300  
1-57

60

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Affton 4830
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital #2		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 3809 Union Rd.
3. NAME OF DECEASED (Type or print) First Middle Last JAMES ALBERT SUTTON			4. DATE OF DEATH Month Day Year Apr. 3 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1924
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Window Washer-Ideal		10b. KIND OF BUSINESS OR INDUSTRY WINDOW CLEANING C.	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Arthur Sutton	13b. MOTHER'S MAIDEN NAME Stella Hannah
14. NAME OF HUSBAND OR WIFE Lorraine Sutton		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes World War 2	16. SOCIAL SECURITY NO. 498-16-0948
17. INFORMANT Lorraine Sutton		Address 3809 Union Rd.	
18. CAUSE OF DEATH (Enter only one cause operative for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Skull DUE TO (b) Brain Injury E 902.3 DUE TO (c) Internal Hemorrhage PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease mentioned in PART I (a) suffered with meningitis which disease was			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (If not described in PART II, PART I (a) (b) or (c)) Blud. about 12 p.m. April 3rd, 1959. Following accident		
20c. TIME OF INJURY Hour Month, Day, Year 2:12 p.m. 4 3 59	20d. PLACE OF INJURY (e.g., in or about home, farm, school, office bldg., etc.) 191 Adel		
20e. CITY, TOWN, OR LOCATION St. Louis Mo	20f. COUNTY STATE		
21. I attended the deceased from _____ 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 Patrick Taylor Caraway		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 4.6.59		22d. (Degree or title) 3	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Apr. 7, 1959	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway		25. DATE RECD. BY LOCAL REG. APR 6 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

**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 *Richard W. Storey*

Licensed Embalmer No. *4007*.....

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.