

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015832

STATE FILE NUMBER  
2 3530  
Registration File

XC 3080660  
SL 19520  
MAY 1 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

300  
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 MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N GRAND ST LOUIS MO		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST LOUIS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION WETS ADMIN HOSPITAL		Length of stay in lb 11 DAYS	d. STREET ADDRESS (If outside, give location) 3938A ENRIGHT
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First FOSTER Middle Last TERRELL			4. DATE OF DEATH Month APRIL Day 7 Year 1959		
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/18/87	9. AGE (In years last birthday) 72	10. UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) MOBILE, ALABAMA		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME ARTHUR TERRELL		13b. MOTHER'S MAIDEN NAME ADINE McCARTHY		14. NAME OF HUSBAND OR WIFE MARY TERRELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address VA HOSP RECORDS 915 N GRAND ST LOUIS, MO		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:				INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) ASPHYXIA				4 HOURS	
DUE TO (b) TRACHEAL COMPRESSION				15 YEARS	
DUE TO (c) SYPHILITIC ANEURYSM OF AORTA 022X				19 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> NONE <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. attended the deceased from Death occurred at 7:25 PM		3/27/59 to 4/7/59 and last saw him alive on 4/7/59		
22a. SIGNATURE SHELDON SCHOEN M.D.		22b. ADDRESS VAH, ST LOUIS, MISSOURI		22c. DATE SIGNED 4/8/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4/13/59	23c. NAME OF CEMETERY OR CREMATORY National Cemetary	23d. LOCATION (City, town, or county) Jefferson Barr	(State) Mo
24. FUNERAL DIRECTOR Boyd Bros		ADDRESS 3706 Finney Ave	25. DATE RECD. BY LOCAL REG. APR 9 '59	26. REGISTRAR'S SIGNATURE Earl Smith M.D.

S.P.

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. ~~12787~~ working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Henry C. Williams* .....

Licensed Embalmer No. *4781* .....  
P. O. Address *1205 V. I. T. O. N* .....

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.