

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015930
STATE FILE NUMBER
2 2785

FILED MAY 1 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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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	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN ST. LOUIS, MO.	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		d. STREET ADDRESS (If outside, give location) 1415 HILLS TER.	
3. NAME OF DECEASED (Type or print) First Middle Last BABY BOY WELLINGTON		4. DATE OF DEATH Month Day Year MARCH 3, 1959	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/1/59
9. AGE (In years last birthday)		10. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME PERCY		13b. MOTHER'S MAIDEN NAME EDDIE MAE ?????	
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) no	
16. SOCIAL SECURITY NO. none		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) Prematurity Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Pulmonary Arteriosclerosis with Congestion DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 762.5			INTERVAL BETWEEN ONSET AND DEATH
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 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. I attended the deceased from 3/1/59 to 3/2/59 and last saw her/him alive on 3/2/59 Death occurred at 2:15 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Michael S. Possgay, M.D.		22b. ADDRESS 1515 LAFAYETTE AVE	
22c. DATE SIGNED 3/3/59		23a. BURIAL, CREMATION, REMOVAL (Specify)	
23b. DATE 3-31-59		23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
23d. LOCATION (City, town, or county) (State) St. Louis, Mo.		24. FUNERAL DIRECTOR ADDRESS Rowland Akew 404 Manchester	
25. DATE RECD. BY LOCAL REG. MAR 19 '59		26. REGISTRAR'S SIGNATURE Good Smith, M.D.	

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.