

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016343

STATE FILE NUMBER

FILED MAY 15 1959

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 1233

300
1-57
2
59
1
6

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) LEMAY		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MT ST ROSE HOSPITAL		d. STREET ADDRESS MILNER HOTEL	
Length of stay in lb 2 DAYS		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First OSCAR Middle E Last POURCELY			4. DATE OF DEATH Month MAY Day 3 Year 1959		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 13, 1893	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY CLERK	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.	12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME JOHN POURCELY		13b. MOTHER'S MAIDEN NAME SARAH MORTON		14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give WW-1 date of service) YES		16. SOCIAL SECURITY NO. 488-01-7957		17. INFORMANT CORREAN ADAMS Address 4932 DELOR	

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			INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) OO2X			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 <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 MAY 1, 1959 to MAY 3, 1959 and last saw ^{her} him alive on MAY 1, 1959 Death occurred at 8 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Hubert Sweet MO			22b. ADDRESS 508 N Grand		22c. DATE SIGNED 5-4-59

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 5/5/1959	23c. NAME OF CEMETERY OR CREMATORY MT. OLIVE CEMETERY	23d. LOCATION (City, town, or country) (State) ST. LOUIS CO., MO.
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24. FUNERAL DIRECTOR J L ZIEGENHEIN & SONS	ADDRESS 7027 GRAVOIS	25. DATE RECD. BY LOCAL REG. 5-4-59	26. REGISTRAR'S SIGNATURE John C. Murphy m.d.
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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 *Donald E. Berg*

Licensed Embalmer No. *4863*

P. O. Address *7027 Hawaii*

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.