

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019100  
STATE FILE NUMBER  
Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_  
Registered No. 4473

FILED MAY 18 1959

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X

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Michigan</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>Muskegon Heights</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's</b>		d. STREET ADDRESS (If outside, give location) <b>2412 Wood Street</b>	
Length of stay in 1b <b>3 days</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle _____ Last <b>DEW</b>			4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 14, 1919</b>
9. AGE (In years last birthday) <b>40</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during last 12 months of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private Family</b>	11. BIRTHPLACE (City and state or country) <b>Madison, Arkansas</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>WILLIE BROCK</b>	
13b. MOTHER'S MAIDEN NAME <b>MARY HOOKS</b>		14. NAME OF HUSBAND OR WIFE <b>---</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mary Wilson, 2412 Wood St., Muskegon, Mich</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Hypertension</b> DUE TO (c) <b>Chronic Nephritis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>592x</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>1 wk</b> <b>1 wk</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ Month _____ Day _____ Year _____ 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 death occurred at <b>5/3/59 7:30 P</b> to <b>5/3/59 1:00 P</b> and last saw her alive on <b>5/3/59</b> and to the best of my knowledge from the causes stated.			
22a. SIGNATURE <b>Mary Wilson</b> (Degree or title)		22b. ADDRESS <b>1324 Maple Ave 6 St, Dep 575709</b>	
22c. DATE SIGNED <b>5/5/59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5/9/59</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Garden of Memory</b>		23d. LOCATION (City, town, or county) (State) <b>Stookey Township, Ill.</b>	
24. FUNERAL DIRECTOR <b>Marion's Office</b> 2114 <b>MO.</b> Ave. <b>E. St. Louis, Ill.</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 6 '59</b>	
26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b> <b>mgs</b>			

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 *Frank Prater* .....

Licensed Embalmer No. *4356* .....

P. O. Address *Shiloh, Mo.* .....

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.