

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019278

STATE FILE NUMBER

2-5101

FILED JUN 11 1959 Registration District No. _____ Primary Registration District No. _____ Registrar _____

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 ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
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 MO. BAPTIST HOSP.		d. STREET ADDRESS (If outside, give location) 3914 NO. TAYLOR	
Length of stay in lb		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last DAVID LEE HURST			4. DATE OF DEATH Month Day Year MAY 26 1959
5. SEX MALE <input checked="" type="checkbox"/>	6. COLOR OR RACE WHITE <input checked="" type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 26, 1959
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO. <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION		12. CITIZEN OF WHAT COUNTRY? U S A <input checked="" type="checkbox"/>	
13a. FATHER'S NAME JESSIE HURST		13b. MOTHER'S MAIDEN NAME MINNIE TOLLISON	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 MINNIE TOLLISON 4479 ST. LOUIS AVE.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity (32 weeks gestation)</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Probable Hyaline Lung.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>773.5</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>
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. Month, Day, Year			
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 <u>5-26-59</u> , to <u>5-26-59</u> and last saw her alive on <u>5-26-59</u> Death occurred at <u>8:15 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>William H. Garis M.D.</u>		22b. ADDRESS <u>3121 N. Grand.</u>	
22c. DATE SIGNED <u>5-27-59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>MAY 28, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CITY CEMETERY</u>
23d. LOCATION (City, town, or county) <u>JONESBURG, ARKANSAS</u>		(State)	
24. FUNERAL DIRECTOR <u>EDDIE TOLLISON 4479 ST. LOUIS AVE.</u>		25. DATE RECD. BY LOCAL REG. <u>MAY 27 '59</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

L.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

NOT EMBALMED
Signed M W Rueter

Licensed Embalmer No. 4865
P. O. Address St Louis, 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.