

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019447

STATE FILE NUMBER

2 4836

FILED JUN 1 1959 Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY <u>RANDOLPH</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>CHESTER</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>JEWISH HOSPITAL</u>		Length of stay in lb <u>7 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>1307 SOLOMON</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Oppie Neal Mizer</u>			4. DATE OF DEATH Month Day Year <u>5-16-1959</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 14, 1907</u>	9. AGE (In years last birthday) <u>52</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MILL WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FLOUR MILL</u>	11. BIRTHPLACE (City and state or country) <u>SNEEDVILLE, TENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>LOGAN MIZER</u>		13b. MOTHER'S MAIDEN NAME <u>NANCY COLLINS</u>		14. NAME OF HUSBAND OR WIFE <u>EDNA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES PEACETIME</u>		16. SOCIAL SECURITY NO. <u>344-01-0570</u>	17. INFORMANT Address <u>Mrs. Oppie Mizer, Chester, Ill.</u>		
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>LEFT OCCIPITAL BRAIN ABCESS</u>					INTERVAL BETWEEN ONSET AND DEATH. <u>8 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>STAPHYLOCOCCAL SEPTICEMIA</u>					<u>13 days</u>
DUE TO (c) <u>FURUNCULOSIS</u>					<u>15 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>690.7</u>					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 <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.) <u>ST. LOUIS</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>ST. LOUIS ST. LOUIS MO.</u>	
21. I attended the deceased from <u>5/9/59</u> to <u>5/16/59</u> and last saw ^{him} <u>live on 5/16/59</u> Death occurred at <u>4:00 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Robert Rubin M.D.</u>			22b. ADDRESS <u>246 S. Kingsbury Way, St Louis</u>		22c. DATE SIGNED <u>5/18/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>5-19-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PARADISE CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>RANDOLPH Co. ILL.</u>
24. FUNERAL DIRECTOR <u>ALBERT H. HOPPE, 4700 WASHINGTON</u>		25. DATE RECD. BY LOCAL REG. <u>MAY 18 '59</u>		26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>	

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 *Em R Cadwell*

Licensed Embalmer No. *4077*

P. O. Address *St Louis*

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.