Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-019535

STATE FILE NUMBER 24508

FILED MAY 22 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Chronic Hosp. — Length of stay in Ib: 1 yr.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 3104 Caroline — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Elizabeth — Middle: — Last: Preston

4. DATE OF DEATH: Month 5 Day 6 Year 59

5. SEX: female

6. COLOR OR RACE: col.

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: May 7, 1892

9. AGE (In years last birthday): 66 — 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): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (City and state or country): Mo.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME: Frank Jones

13b. MOTHER'S MAIDEN NAME: Lillie Arnold

14. NAME OF HUSBAND OR WIFE: --Archie Preston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Helen Shaw — Address: 6128 Minerva Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6 days.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 491X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Generalized Arteriosclerosis — 1 yr.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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 WORK [ ] NOT WHILE AT WORK [ ]

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 5-15-58, to 5-6-59 and last saw her/him alive on 5-6-59
Death occurred at 4:00 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John W. Beckham, M.D.

22b. ADDRESS: 5800 Arsenal

22c. DATE SIGNED: 5/7/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 5/12/59

23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis County, Mo.

24. FUNERAL DIRECTOR: Charles J. Gates — ADDRESS: 4107 Finney

25. DATE RECD. BY LOCAL REG.: MAY 8 '59

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 embalme

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. ~~4580~~ 4341

P. O. Address 4107 Finney Av

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failur 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.