

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019540
STATE FILE NUMBER

FILED JUN 1 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 4777**

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 type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St Louis City Hospital # 1		d. STREET ADDRESS (If outside, give location) 2610 Bernard	
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Henry Middle NMN Last Quarles			4. DATE OF DEATH Month 5 Day 13 Year 59		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1887	9. AGE (In years by birthday) 71	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 None	11. BIRTHPLACE (City and state or country) Tennessee	12. CITIZEN OF WHAT COUNTRY? US. S. A.	
13a. FATHER'S NAME Willie Quarles		13b. MOTHER'S MAIDEN NAME Sallie Quarles		14. NAME OF HUSBAND OR WIFE Barbara Quarles	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown) (If yes give year and dates of service)	16. SOCIAL SECURITY NO. 495-22-5416	17. INFORMANT Barbara Quarles	Address 2610 Barnard
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 9 wks.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cerebrovascular Accident	
	DUE TO (c) Congestive failure, anemia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331x		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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 5 - 10 - 59 to 5 - 13 - 59 and last saw him alive on 5 - 13 59 Death occurred at 8:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) Charles G. Pharyng M.D.	22b. ADDRESS 1515 LaFayette Ave	22c. DATE SIGNED 5 13 59

23a. BURIAL, CREMATION, REBURYAL (Specify) Burial	23b. DATE 5/18/59	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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24. FUNERAL DIRECTOR E. B. Hoone	ADDRESS 1221 N. Grand Blvd.	25. DATE RECD. BY LOCAL REG. MAY 16 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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1-57

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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 *James D. Jones*

Licensed Embalmer No. 4757
P. O. Address 122114

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.