Health, Welfare Public Service

FILED MAY 18 1959

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-019657

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 4457

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MISSOURI — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: VAH, 915 NO. GRAND — Length of stay in 1b: 6 DAYS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: ILLINOIS
b. COUNTY
c. CITY OR TOWN: EDWARDSVILLE — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 306 E. UNION — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First RANDOLPH Middle STANLEY Last
4. DATE OF DEATH: Month Day Year 5/4/59

5. SEX: MALE 2
6. COLOR OR RACE: NEGRO
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X] 3
8. DATE OF BIRTH: 6/29/81
9. AGE (In years last birthday): 77 — 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): LABORER - UNEMPLOYED
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): ORMOND, FLORIDA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: ZHALL STANLEY
13b. MOTHER'S MAIDEN NAME: ANNIE DAY
14. NAME OF HUSBAND OR WIFE: - - - - -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW-I
16. SOCIAL SECURITY NO.: 414-16-2365
17. INFORMANT: VAH, 915 NO. GRAND AVE., ST. LOUIS, MO.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIAC ARRHYTHMIA	½ HOUR
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	RESPIRATORY FAILURE	2 YEARS
DUE TO (c)	INTERSTITIAL FEBROSIS OF LUNG 525X	2 ½ YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): PULMONARY EMPHYSEMA

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

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ] NONE
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 4/28/59, to 5/4/59 and last saw him alive on 5/4/59
Death occurred at 10:00 AM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: V. A. Codiga (Degree or title) V. A. CODIGA, M.D.
22b. ADDRESS: VAH, ST. LOUIS, MO.
22c. DATE SIGNED: 5/4/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 5/7/59
23c. NAME OF CEMETERY OR CREMATORY: NATIONAL CEMETERY
23d. LOCATION (City, town, or county) (State): Jefferson Barracks, Mo.

24. FUNERAL DIRECTOR: G. Wade Granberry
ADDRESS: 4202 Finney Ave.
25. DATE RECD. BY LOCAL REG.: MAY 6 '59
26. REGISTRAR'S SIGNATURE: Karl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 Edward A. Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 Finney Ave.

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.