

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019704
STATE FILE NUMBER

FILED JUN 4 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's **8 4844**

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-57

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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 Saint Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Saint Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1706 Goode Ave.		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 1706 Goode Avenue Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Walter Middle Thomas Last Thomas			4. DATE OF DEATH Month May Day 16 Year 1959	
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 5, 1885	9. AGE (In years last birthday) 74 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter	10b. KIND OF BUSINESS OR INDUSTRY Electric Co.	11. BIRTHPLACE (City and state or country) Belleville, Illinois	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Kerber, Thomas	13b. MOTHER'S MAIDEN NAME Emma N. Harris	14. NAME OF HUSBAND OR WIFE
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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. 493-05-0988	17. INFORMANT Address Pauline Payne 3747 Palm Avenue
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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) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) 260x		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 WORK <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 _____
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21. I attended the deceased from _____ and last saw her/him alive on _____
Death occurred at **15017** on the date stated above; and to the best of my knowledge, from the causes stated

22a. SIGNATURE <i>Pauline Payne</i> (Deputy Registrar)	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 5/18/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5-21-59	23c. NAME OF CEMETERY OR CREMATORY Father Dickson Cemetery	23d. LOCATION (City, town, or county) St. Louis County, Mo.
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24. FUNERAL DIRECTOR Metropolitan Funeral System, Inc.	ADDRESS 5010 Enright	DATE RECD. BY LOCAL REG. MAY 19 '59	26. REGISTRAR'S SIGNATURE <i>Paul Smith, M.D.</i>
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

mjb

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 *John H. Cunningham*

Licensed Embalmer No. *4476*
P. O. Address *24059 MARCH*

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.