

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019705
STATE FILE NUMBER
2 4470

FILED MAY 22 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 Illinois b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Tolson Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Little Rock Hospitals, Inc.		Length of stay in lb 17 days	d. STREET ADDRESS Route #1 Box 18 (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First James Middle - Last Tice			4. DATE OF DEATH Month May Day 2 Year 1959
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Mar 12, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Section Laborer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) Jackson, Tennessee
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME UNKNOWN	
13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE -----	
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. 356-05-0518	17. INFORMANT Allie Will Lewis, Rt. 1, Box 16, Address E. St. Louis, Ill.
18. CAUSE OF DEATH (Enter only one code per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Atherosclerosis Arterio Scler. H. Disease Hypertensive H. Disease Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Obesity			INTERVAL BETWEEN ONSET AND DEATH 420-1
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 _____ 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 Apr. 15, 1959 to May 2, 1959 and last saw him alive on May 2, 1959 Death occurred at 11.05 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
21a. SIGNATURE Charles Francis, M.D. (Degree or title)		22b. ADDRESS 1755 So Grand	
22c. DATE SIGNED 5-5-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/7/59	23c. NAME OF CEMETERY OR CREMATORY Booker Washington
23d. LOCATION (City, town, or county) Centreville Township, Ill.		(State)	
24. FUNERAL DIRECTOR Marion's Office ADDRESS 2114 Missouri Ave. E. St. Louis, Ill.		25. DATE RECD. BY LOCAL REG. MAY 6 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

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 *Frank Probst*

Licensed Embalmer No. *7356*
P. O. Address *St Louis, Mo*

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.