

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019765

STATE FILE NUMBER

Registration No. **4461**

FILED MAY 18 1959

Registration District No.

Primary Registration District No.

Registration No.

300
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57
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1. PLACE OF DEATH a. COUNTY None		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 St. Louis TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR St. Louis TOWN
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR St. Mary's Infirmary INSTITUTION		Length of stay in lb	d. STREET ADDRESS 5963 Julian Ave.
3. NAME OF DECEASED (Type or print) First Daisy Middle Mamie Last WHITFIELD		4. DATE OF DEATH Month May Day 4 Year 1959	
5. SEX Female	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 Feb. 14, 1905
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years) at (birth) day 54
11. BIRTHPLACE (City and state or country) Newellton, Louisiana		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Ephram Nash		13b. MOTHER'S MAIDEN NAME Addie Ash	14. NAME OF HUSBAND OR WIFE Edward Whitfield
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, state or unknown) (If yes, war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Address Edward Whitfield, 5963 Julian Ave
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Thrombosis Hypertensive Heart Disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) 443x			INTERVAL BETWEEN ONSET AND DEATH 2 days
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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 April 30 to May 4 and last saw her alive on May 4, 1959 Death occurred at 11:55A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE J. W. Howard (Degree or title)		22b. ADDRESS M.D. Lix Ave., Kinloch, Mo.	22c. DATE SIGNED 5/6/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5/10/59	23c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.	23d. LOCATION (City, town, or county) (State) Berkeley City, Mo.
24. FUNERAL DIRECTOR Cunningham & Moore, 2405 Marcus		25. DATE RECD. BY LOCAL REG. MAY 6 '59	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 *John X Cunningham*
Licensed Embalmer No. 4476
P. O. Address 2405 Marcus

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.