

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022762

STATE FILE NUMBER

FILED JUL 1 1959 Registration District No. Primary Registration District No. Registrar No. 5784

300  
-57  
28  
94  
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>2637A Market Pl.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>Cauthen</b>			4. DATE OF DEATH Month Day Year <b>6 9 59</b>		
--	--	--	---	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-9-59</b>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min. <b>2 32</b>
-----------------------	----------------------------------	---	-----------------------------------	---------------------------------	--------------------------------	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (City and state or country) <b>Saint Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
--	--	--	--

13a. FATHER'S NAME <b>Andrew Cauthen</b>	13b. MOTHER'S MAIDEN NAME <b>Ruby Graham</b>	14. NAME OF HUSBAND OR WIFE <b>none</b>
---	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Mary P. Jett, R.N.</b>	Address <b>2601 N. Whittier</b>
--	--	--	------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Premature birth</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last.	DUE TO (b)	
	DUE TO (c) <b>7625</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Atelectasis (partial)</b>		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 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
--	--	---

21. I attended the deceased from **6-9-59** to **6-9-59** and last saw <sup>him</sup> alive on **6-9-59**  
Death occurred at **6:08 p.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Paul P. White, M. D.</b>	22b. ADDRESS <b>2601 N. Whittier</b>	22c. DATE SIGNED <b>6-11-59</b>
---	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>6-30-59</b>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
---	-----------	---	--

24. FUNERAL DIRECTOR <b>Rowland Aker 410 Manchester</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>JUN 18 '59</b>	26. REGISTRAR'S SIGNATURE <b>Paul P. White, M. D.</b> m. 8.13.
--	---------	---	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 ..... Signed .....  
Signature of Student Embalmer ..... Licensed Embalmer No. ....  
P. O. Address .....

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.