

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022825

STATE FILE NUMBER

8
FILED JUL 1 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **5846**

300
1-57
6
191
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		d. STREET ADDRESS (If outside, give location) 716 N. Leonard	

3. NAME OF DECEASED (Type or print) First HOOPER Middle Last DENT			4. DATE OF DEATH Month JUNE Day 16 Year 1959		
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5. SEX Male	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 June 6, 1902	9. AGE (In years last birthday) 57	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) laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Ala.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME George Dent	13b. MOTHER'S MAIDEN NAME Lula Adell	14. NAME OF HUSBAND OR WIFE Florence Dent
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) None	16. SOCIAL SECURITY NO.	17. INFORMANT Florence Dent Address 716 N. Leonard
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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) SEPTICEMIA, ORGANISM UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) MEDIASTINITIS	
	DUE TO (c) PERFORATED ESOPHAGUS	
PART II. OTHER SIGNIFICANT CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ADVANCED CIRCOSIS		19. WAS AUTOPSY PERFORMED? 2 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.)
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20c. TIME OF INJURY Hour _____ 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
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21. I attended the deceased from **5/2/59** to **6/16/59** and last saw her/him alive on **6/16/59**
Death occurred at **3A.M** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Lloyd F. Walk, M.D.	22b. ADDRESS 1515 LAFAYETTE AVE	22c. DATE SIGNED 6/16/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) 6/20/59	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY Father Dickson	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
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24. FUNERAL DIRECTOR Reliable Funeral 1389 N. Union	25. DATE RECD. BY LOCAL REG. JUN 19 1959	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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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
Signature of Student Embalmer

Signed *John K. Cunningham*
Licensed Embalmer No. *4476*
P. O. Address *2465 Marce*

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.