

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022909

STATE FILE NUMBER

2 5747

FILED JUL 1 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Madison | |
| 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 Madison Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Infirmary | | Length of stay in lb 8 days | d. STREET ADDRESS (If outside, give location) 916 Webster St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First BOOKER Middle _____ Last GERMANY | | | 4. DATE OF DEATH Month June Day 14 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 Sept 22, 1891 | 9. AGE (In years at birthday) 67 | 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) Retired Laborer | 10b. KIND OF BUSINESS OR INDUSTRY Steel Foundry | 11. BIRTHPLACE (City and state or country) Augusta, Ark, | 12. CITIZEN OF WHAT COUNTRY? USA |
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| 13a. FATHER'S NAME Wesley Germany | 13b. MOTHER'S MAIDEN NAME Jennie Thompson | 14. NAME OF HUSBAND OR WIFE Emma Germany |
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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. Unknown | 17. INFORMANT Address Emma Germany-916 Webster St., Madison, Ill. |
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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) Congestive heart failure hypertension Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH 2 mth 6 wks |
| 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"/> |

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| 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 <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 Augusta, Arkansas |
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| 21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated. | |
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| 22a. SIGNATURE Walter G. Younger M.D. | (Degree or title) | 22b. ADDRESS 4635 Easton | 22c. DATE SIGNED 6/15/59 |
|---|-------------------|------------------------------------|------------------------------------|

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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 6/20/59 | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town, or county) (State) Augusta, Arkansas |
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| 24. FUNERAL DIRECTOR Marshall Funeral Home- | ADDRESS 2207 Missouri Ave East St. Louis, Ill. | 25. DATE RECD. BY LOCAL REG. JUN 16 '59 | 26. REGISTRAR'S SIGNATURE Loed Smith, M.D. |
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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 *Thomas M. Labz*

Licensed Embalmer No. 4479
P. O. Address East St. Louis, Il

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.