

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022993

FILED JUL 13 1959

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

STATE FILING NUMBER  
2 6254  
Registration No. \_\_\_\_\_

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, Missouri</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>St. Louis Maternity</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>1216 Temple Place</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Hines</b>			4. DATE OF DEATH Month Day Year <b>June 16 1959</b>
5. SEX <b>Female</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>June 16, 1959</b>
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Mins <b>25</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>		13a. FATHER'S NAME <b>Ollie NMN Hines</b>	
13b. MOTHER'S MAIDEN NAME <b>Mary NMN Wright</b>		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)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Ollie and Mary Hines</b>		Address <b>1216 Temple Place</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) <u>Respiratory &amp; Cardiac Arrest</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Prematurity (Fetaluric incompatible with life) 25 min.</u> DUE TO (c) <u>Unknown cause</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>none</u>			INTERVAL BETWEEN ONSET AND DEATH <b>7735</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <u>6-16-59</u> to <u>6-16-59</u> and last saw <sup>her</sup> him alive on <u>6-16-59</u> Death occurred at <u>6:20</u> P. M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Walter A. Buch, M.D.</i> (Degree or title)		22b. ADDRESS <b>St. Louis Maternity Hospital</b>	
22c. DATE SIGNED <b>6-25-59</b>		23a. BURIAL, CREMATION, REMOVAL (Specify)	
23b. DATE <b>7-3-59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>	
23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>		(State)	
24. FUNERAL DIRECTOR <i>Rouland aka 4104 Manchester</i>		ADDRESS	
25. DATE RECD. BY LOCAL REG. <b>JUL 2 '59</b>		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All attendees 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 .....

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.**