

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023143

STATE FILE NUMBER
Registration No. 5792

FILED JUL 1 1959

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b		d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
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 county)	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
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 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 _____, 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.					
22a. SIGNATURE		22b. ADDRESS		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION (City, town, or county)		23e. NAME OF FUNERAL HOME		23f. ADDRESS	
24. FUNERAL DIRECTOR		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE	

USE ONLY BLACK INK OR RIBBON TYPEWRITE, IF POSSIBLE.

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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1. PLACE OF DEATH: a. COUNTY: St. Louis, Mo. b. CITY: St. Louis c. FULL NAME OF HOSPITAL OR INSTITUTION: 2626 Papin

2. USUAL RESIDENCE: a. STATE: Mo. b. COUNTY: St. Louis c. CITY OR TOWN: St. Louis d. STREET ADDRESS: 2626 Papin

3. NAME OF DECEASED: Charlie Windsey

4. DATE OF DEATH: 5 29 59

5. SEX: Male 6. COLOR OR RACE: Black 7. MARRIED: NEVER MARRIED: 8. WIDOWED: DIVORCED: 8. DATE OF BIRTH: 5 5 9. AGE: 53

10a. USUAL OCCUPATION: None 10b. KIND OF BUSINESS OR INDUSTRY: None 11. BIRTHPLACE: Mississippi 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: W.C. 13b. MOTHER'S MAIDEN NAME: W.C. 14. NAME OF HUSBAND OR WIFE: W.C.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?: No 16. SOCIAL SECURITY NO.: W.C. 17. INFORMANT: W.C. Taylor

18. CAUSE OF DEATH: PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO (b) Arteriosclerosis DUE TO (c) Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 422.1

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED: _____

20c. TIME OF INJURY: _____ 20d. INJURY OCCURRED WHILE AT NOT WHILE AT WORK 20e. PLACE OF INJURY: _____ 20f. CITY, TOWN, OR LOCATION: St. Louis, Mo.

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.

22a. SIGNATURE: Rowland Aker 22b. ADDRESS: 1200 Clark 22c. DATE SIGNED: 6/6/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Rowland Aker Mortuary Service 23b. DATE: 6-30-1959 23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board 23d. LOCATION (City, town, or county): St. Louis, Mo.

24. FUNERAL DIRECTOR: Rowland Aker Mortuary Service 25. DATE RECD. BY LOCAL REG.: JUN 18 '59 26. REGISTRAR'S SIGNATURE: Rowland Aker

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.