

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023169

STATE FILE NUMBER 5493

Health, Welfare, Public Service
28
300
-57
3

JUN 24 1959 Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Homer Phillips</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>2123 Cass</u> Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle Last <u>MADISON JR</u>			4. DATE OF DEATH Month <u>6</u> Day <u>6</u> Year <u>59</u>			
---	--	--	--	--	--	--

5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-6-1943</u>	9. AGE (In years last birthday) <u>16</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>St Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-S-A</u>	

13a. FATHER'S NAME <u>HARRY MADISON</u>		13b. MOTHER'S MAIDEN NAME <u>Lillian DICKSON</u>		14. NAME OF HUSBAND OR WIFE <u>Lillian Brooks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Lillian Brooks 2123 Cass</u>		

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>Right Lobar Pneumonia (Empyema)</u>		INTERVAL BETWEEN ONSET AND DEATH
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)		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.) <u>490X</u>	
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/him alive on _____
Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Joseph T. Smith</u> 3	22b. ADDRESS <u>1300 Cass</u>	22c. DATE SIGNED <u>6/9/59</u>
--	----------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6-10-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Ste Genevieve-Missouri</u>
--	-----------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS <u>Hill & Radford 1713 N Grand</u>	25. DATE RECD. BY LOCAL REG. <u>JUN 9 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith. M.D.</u> S.P.
--	--	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature. 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 *Leroy M. Bonnistus*

Licensed Embalmer No. *4523*

P. O. Address *4260 Washing*

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.