

pt. Health,
, & Welfare
S. Public
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023361
STATE FILE NUMBER

FILED JUN 18 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. **5525**

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7E
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>East St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Inf.</u>		Length of stay in lb <u>1mo. 5 days</u>	d. STREET ADDRESS (If outside, give location) <u>2701 Missouri</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>David Sample</u>			4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1959</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>Jan. 4, 1936</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNEMPLOYED</u>		10b. KIND OF BUSINESS OR INDUSTRY —	9. AGE (In years) (In birth day) <u>23</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <u>East St. Louis, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William H. Sample</u>		13b. MOTHER'S MAIDEN NAME <u>Annie Robinson</u>	14. NAME OF HUSBAND OR WIFE <u>none</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. <u>Unknown</u>	17. INFORMANT <u>William Sample</u> Address <u>2701. Missouri E. St. Louis, Ill.</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>Sickle Cell Anemia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<u>292.6</u>
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"/>
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 _____ a.m. _____ p.m. Month _____ Day _____ Year _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>May 3, 1959</u> to <u>June 7, 1959</u> and last saw ^{him} <u>6-7-59</u> _{at 1:20 p.m.} on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>A. E. Smith, M.D.</u>		22b. ADDRESS <u>111 Jefferson St. Louis</u>	22c. DATE SIGNED <u>6-9-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6/14/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Booker Washington</u>	23d. LOCATION (City, town, or county) (State) <u>Centreville Township, Ill.</u>
24. FUNERAL DIRECTOR <u>Marion Office</u>		ADDRESS <u>2114 Mo. Ave. E. St. Louis, Ill.</u>	25. DATE RECD. BY LOCAL REG. <u>JUN 9 '59</u>
			26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

MS

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 *Frank Prokoff*

Licensed Embalmer No. *4356*

P. O. Address *St. Louis, Mo*

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.