

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 11 1959

59-026332

DED

Registration District No. 316 Primary Registration District No. \_\_\_\_\_ Registrar's No. 309

STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>St. Francois</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Francois Township</b>		a. STATE <b>Missouri</b> b. COUNTY <b>City of St. Louis</b>		c. CITY OR TOWN <b>St. Louis City Sanitarium</b>	
Length of stay in 1b <b>27Y; 18 das</b>		c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital No. 4</b>		d. STREET ADDRESS (If outside, give location) <b>5400 Arsenal St.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>ED</b> Middle _____ Last <b>LAHY</b>		4. DATE OF DEATH		Month <b>July</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</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>Nov. 11, 1885</b>	9. AGE (last birthday) <b>73</b>	IF UNDER 1 YEAR Months <b>8</b> Days <b>8</b>	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Common labor</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Unknown</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</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) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records, State Hospital No. 4, Farmington, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Aspiration of gastro intestinal contents, post operative</b>						<b>7 das.</b>	
DUE TO (b) <b>Biliary Cirrhosis</b>						<b>4 yrs.</b>	
DUE TO (c) <b>Cholelithiasis and choledocholithiasis</b>						<b>8 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Dementia Praecox Psychosis.</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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 WORK <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 <b>July 3, 1959</b> to <b>July 17, 1959</b> and last saw him alive on <b>July 17, 1959</b>				Death occurred at <b>9:15 P. M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Shirley M. Rowland M.D.</i> (Degree or title)			22b. ADDRESS <b>State Hospital No. 4 Farmington, Missouri</b>			22c. DATE SIGNED <b>7-17-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>July 20, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington Univ. Anat. Dept.</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>	
24. FUNERAL DIRECTOR <b>Via Cozean Funeral Home, Farmington, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>Aug. 7, 1959</b>		26. REGISTRAR'S SIGNATURE <i>Ethel Rudloff</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

*not embalmed*

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.