

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-026408**

**FILED VS JUL 24 1959**

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

Registrar's No. **2 6646**

STATE FILE NUMBER

NEEDED

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Louis</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		Length of stay in 1b	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>Homer G. Phillips</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2251 O'Fallon, Apt. 303</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>John</b> Middle _____ Last <b>Black</b>			<b>4. DATE OF DEATH</b> Month <b>7</b> Day <b>2</b> Year <b>59</b>		
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>7-1-59</b>	<b>9. AGE</b> (last birthday) IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. <b>13</b>	IF UNDER 24 HR
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Saint Louis, Missouri</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>
<b>13a. FATHER'S NAME</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Patricia Black</b>		<b>14. NAME OF HUSBAND OR WIFE</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT</b> Address <b>Hospital Records 2601 N. Whittier</b>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Premature birth, Neonatal death</b>					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) _____ <b>773.5</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____					
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>	
<b>21. I attended the deceased from</b> <b>7-1-59</b> , to <b>7-2-59</b> and last saw <b>him</b> alive on <b>7-2-59</b> Death occurred at <b>8:40</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
<b>22a. SIGNATURE</b> <i>John E. North</i> (degree or title) <b>M. D.</b>			<b>22b. ADDRESS</b> <b>2601 N. Whittier</b>		<b>22c. DATE SIGNED</b> <b>7-8-59</b>
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)	<b>23b. DATE</b> <b>7-31-59</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Anatomical Board</b>	<b>23d. LOCATION</b> (City, town, or county) <b>St. Louis, Mo.</b>	(State)	
<b>24. FUNERAL DIRECTOR</b> <b>Rawland Akers 4104 Manchester</b>		ADDRESS	<b>25. DATE RECD. BY LOCAL REG.</b> <b>JUL 16 59</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Earl Smith M.D.</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*m & B*

**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.

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.