

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026460

FILED VS JUL 24 1959

2 6592

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips | | d. STREET ADDRESS (If outside, give location) 914 No. 19th | |
| Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |

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|---|----------------------------------|---|---|-------------------------------------|--|--|
| 3. NAME OF DECEASED (Type or print) Clifton Bruce | | | 4. DATE OF DEATH Month 7 Day 10 Year 59 | | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 9-5-1891 | 9. AGE (last birthday) 67 | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor | | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (City and state or country) Lakevillage Ark. | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | |

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|--|--|---|--|---|--|
| 13a. FATHER'S NAME Sam Bruce | | 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE None | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 513-01-6331 | | 17. INFORMANT Address Gertrude Bruce Sister Ark | |

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|---|--|---------------|--|
| 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) Chremia | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Chronic Pyelonephritis | undet. | |
| DUE TO (c) 600.0 | | | |
| 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 |

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|---|---|--|--------------|
| 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 **7-6-59** to **7-10-59** and last saw **him** alive on **7-10-59**
Death occurred at **3:22 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

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|--|-------------------------------|---|--|------------------------------------|
| 22a. SIGNATURE (Degree or title) Sydney D. Enass, M.D. | | 22b. ADDRESS 2601 Whittier Street | | 22c. DATE SIGNED 7-13-59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 7-14-1959 | 23c. NAME OF CEMETERY OR CREMATORY Father Dickson | 23d. LOCATION (City, town, or county) (State) 408 S Fillmore | |

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|---|-------------------------------------|--|---|
| 24. FUNERAL DIRECTOR E. J. Golden | ADDRESS 3404 Delmar Blvd, | 25. DATE RECD. BY LOCAL REG. JUL 13 59 | 26. REGISTRAR'S SIGNATURE Keal Smith M.D. |
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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.

Student _____
Signature of Student Embalmer

Signed Leroy M. Barnette

Licensed Embalmer No. 452

P. O. Address 4251 Washington

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.