

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

**59-026540**

FILED VS JUL 24 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 6580** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>51yrs</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Missouri Baptist Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>6123 Westminster</b>	
3. NAME OF DECEASED (Type or print) First <b>LESSIE</b> Middle <b>BATES</b> Last <b>DAVIS</b>		4. DATE OF DEATH Month <b>July</b> Day <b>12</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10/18/1881</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	9. AGE (last birthday) <b>77yrs</b>
11. BIRTHPLACE (City and state or country) <b>Bates City, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>George Bates</b>		13b. MOTHER'S MAIDEN NAME <b>Griffith</b>	
14. NAME OF HUSBAND OR WIFE <b>Dr. Frank L Davis</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Dr. Frank L Davis</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>left intracerebral hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 mos.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arteriosclerosis</b>		DUE TO (c) <b>331x</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)	
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>Feb. 2, 1944</b> , to <b>July 12, '59</b> and last saw him alive on <b>July 11, 1959</b> Death occurred at <b>3:35 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Robert M. Smith M.D.</b>		22b. ADDRESS <b>114 N. Taylor</b>	
22c. DATE SIGNED <b>7-13-59</b>		23. NAME OF CEMETERY OR CREMATORY <b>Jefferson Barracks Natl</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>July 14, 1959</b>	
23c. LOCATION (City, town, or county) <b>St. Louis Co. Mo.</b>		24. FUNERAL DIRECTOR <b>Alexander &amp; Sons 6175 Delmar</b>	
25. DATE RECD. BY LOCAL REG. <b>JUL 13 '59</b>		26. REGISTRAR'S SIGNATURE <b>Robert M. Smith, M.D.</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr Robert M Smith

#5 Lindworth Lane

114 N Taylor

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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

Joe E. McCulloch

Licensed Embalmer No. 2760

P. O. Address 6170

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.

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