

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 24 1959

59-026989

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **2 6463**

DEED

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b> Length of stay in 1b _____  c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____  c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  d. STREET ADDRESS (If outside, give location) <b>3966 Delmar</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Denise</b> Middle <b>Lynn</b> Last <b>Moten</b>			<b>4. DATE OF DEATH</b> Month <b>7</b> Day <b>7</b> Year <b>59</b>		
<b>5. SEX</b> <b>Fem.</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"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>7-5-59</b>	<b>9. AGE (last birthday)</b> _____	<b>IF UNDER 1 YEAR</b> Months _____ Days <b>2</b> <b>IF UNDER 24 HR</b> Hours _____ Min. _____
<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>George Moten</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Daisy Lee Latham</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> <i>Hospital Records</i>		<b>Address</b> <b>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 _____  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 type="checkbox"/> NO <input checked="" 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"/> <b>NOT WHILE AT WORK</b> <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>7-5-59</b> , to <b>7-7-59</b> and last saw her <del>xxx</del> alive on <b>7-7-59</b> Death occurred at <b>3:25 a.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
<b>22a. SIGNATURE</b> <i>John E. Whittier</i> (Degree or title) <b>M. D.</b>			<b>22b. ADDRESS</b> <b>2601 N. Whittier</b>		<b>22c. DATE SIGNED</b> <b>7-7-59</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> <i>Rowland Akel 4104 Manchester</i> ADDRESS _____		<b>25. DATE RECD. BY LOCAL REG.</b> <b>JUL 9 59</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>Harold Smith M.D.</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.

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.