

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027237

FILED VS JUL 30 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's **8 6757** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 65 Years		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6028a. Etzel Ave				d. STREET ADDRESS (If outside, give location) 6028a. Etzel Ave		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Langhorne Sperry				4. DATE OF DEATH Month Day Year July 20, 1959			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3/20/80	9. AGE (last birthday) 79	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Adv. Manager (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Polk Co		11. BIRTHPLACE (City and state or country) Daleville, Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Jacob Sperry			13b. MOTHER'S MAIDEN NAME Katherine Langhorne			14. NAME OF HUSBAND OR WIFE Katherine Sperry	
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. None		17. INFORMANT Address Mrs Katherine Sperry 6028a. Etzel Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Volunteers of Stomach DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Takes Dorsalis 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 INTERVAL BETWEEN ONSET AND DEATH 4 days							
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 7-16-59 to 7-20-59 and last saw her/him alive on 7-19-59 Death occurred at 7 a.m. 7-20-59 m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Alan McGehee M.D.				22b. ADDRESS 100 N Euclid Ave			22c. DATE SIGNED 7-20-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/22/59	23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri		
24. FUNERAL DIRECTOR ADDRESS Alexander & Sons 6175 Delmar Blvd				25. DATE RECD. BY LOCAL REG. JUL 20 '59		26. REGISTRAR'S SIGNATURE Loal Smith, M.D.	

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: jos. E. McCulloch

Licensed Embalmer No. 2460

P. O. Address 6190 200

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.

Embalmer's Name _____