

PR 8-4
pt. Health,
& Welfare
S. Public
Health Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-027249
STATE FILE NUMBER
Registrar 2 6816

FILED VS AUG 4 1959

Registration District No. _____ Primary Registration District No. _____ Registrar 2 6816

00
S. 300
v. 1-57
99.2

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE BIRTH # 9412

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE			b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS MO			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			c. CITY OR TOWN ST LOUIS MO				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4356 Delmar			Length of stay in lb			d. STREET ADDRESS (If outside, give location) H356-DELMAR				
3. NAME OF DECEASED (Type or print) First CARLA Middle AKA-STOVALL (CARLA STOBALL)			4. DATE OF DEATH Month Day Year 7-21-59							
5. SEX FEMALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-23-59		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min. 1 28		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			10b. KIND OF BUSINESS OR INDUSTRY NONE			11. BIRTHPLACE (City and state or country) ST. LOUIS- MO			12. CITIZEN OF WHAT COUNTRY? U.S.A-	
13a. FATHER'S NAME MALVEN-STOBALL			13b. MOTHER'S MAIDEN NAME JONES MARKA-STOBALL			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)			16. SOCIAL SECURITY NO.			17. INFORMANT Address MARK-STOBALL H356-DELMAR				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Suffocation.</i> DUE TO (b) <i>E924.0</i> DUE TO (c) <i>18</i> PART II. OTHER SIGNIFICANT CONDITION <i>Suffering while sleeping</i> <i>in bed with mother</i> <i>in home at 4356 Delmar on</i> <i>or about July 21, 1959.</i>								INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT <input checked="" 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.) <i>in home at 4356 Delmar on</i> <i>or about July 21, 1959.</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <i>7 21 59</i>			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.) <i>192 Home</i>			20f. CITY, TOWN, OR LOCATION COUNTY STATE <i>St Louis MO</i>	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <i>Catriet J. Taylor Coroner</i>						22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>7.22.59</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVE</i>		23b. DATE <i>7-23-59</i>		23c. NAME OF CEMETERY OR CREMATORY <i>FATHER DICKSON CEM</i>			23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS- COUNTY- MO</i>			
24. FUNERAL DIRECTOR <i>PEASTON FUNERAL 3615 EASTON</i>				25. DATE RECD. BY LOCAL REG. <i>JUL 22 59</i>		26. REGISTRAR'S SIGNATURE <i>Loed Smith, M.D.</i>				

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Hallace R. Williams*.....
5135 Latus
Licensed Embalmer No. *4926*.....

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.