

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-027294  
STATE FILE NUMBER

FILED JUL 17 1959 Registration District No. Primary Registration District No. Registrar No. 6031

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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri. b. COUNTY St. Louis.	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN Wellston. 4311	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer Phillips Hospital		d. STREET ADDRESS (If outside, give location) 6454 Wellsmar	
3. NAME OF DECEASED First Middle Last Charles Dale Torrence			4. DATE OF DEATH Month Day Year June 21, 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 17, 1916
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furniture Mover		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Albion, Illinois.
13a. FATHER'S NAME Frank Torrence		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Ola Mae Torrence
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. Nil.		16. SOCIAL SECURITY NO.	17. INFORMANT Address Robert L. Torrence, 6454 Wellsmar
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>Intra cerebral hemorrhage probably spontaneous.</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 331x
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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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 _____ 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 (In degree or title) <i>Patrick P. Taylor Coroner</i>		22b. ADDRESS 1300 Clark	22c. DATE SIGNED 6-25-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6-26-59	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe Inc., 4700 Washington,		25. DATE RECD. BY LOCAL REG. JUN 25 '59	26. REGISTRAR'S SIGNATURE <i>Loan Smith. M.D.</i>

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 *G. W. Wilkinson*

Licensed Embalmer No. *3575*

P. O. Address *St. Louis*

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.