

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027299

FILED VS AUG 5 1959 ANATOMICAL BOARD RELEASE

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7039**

STATE FILE NUMBER

INDEXED

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		Length of stay in lb	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 BARNES HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 508 PINE STREET Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First LORETTA Middle E. Last TRUITT			4. DATE OF DEATH Month JULY Day 21 Year 1959			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	8. DATE OF BIRTH 1925	9. AGE (last birthday) 33	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATRESS		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) KENTUCKY	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE UNKNOWN		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNKNOWN	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT BARNES HOSPITAL	Address 600 SO. KINGSHIGHWAY
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EPIDERMOID CARCINOMA OF URINARY BLADDER		INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 1810		

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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____ Month, Day, Year _____
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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 ST. LOUIS	COUNTY ST. LOUIS	STATE MISSOURI
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21. I attended the deceased from **JUNE 4, 1959** to **JULY 21, 1959** and last saw her/him alive on **JULY 21, 1959**
 Death occurred at **1:50 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>C. D. Vermillion, M.D.</i>	(Degree or title) M. D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 7/21/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) 7-31-59	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) St. Louis, Mo.	(State)
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24. FUNERAL DIRECTOR Cardinal Aker 410 4 Manchester	ADDRESS	25. DATE RECD. BY LOCAL REG. JUL 30 1959	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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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.