

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027424

FILED VS JUL 21 1959

Registration District No. 317 Primary Registration District No. _____ Registrar's No. 1902

STATE FILE NUMBER

1. PLACE OF DEATH		USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY	<u>St. Louis</u>	STATE	<u>Missouri</u> b. COUNTY <u>St. Louis</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN	<u>Clayton</u>	Length of stay in City or Town	<u>3 days</u> c. CITY OR TOWN <u>Hazelwood</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
<u>St. Louis County Hospital</u>		<u>407 Woodlawn</u>	

3. NAME OF DECEASED (Type or print) First Middle Last			4. DATE OF DEATH Month Day Year				
<u>Edna Deere</u>			<u>7-13-1959</u>				
5. SEX	6. COLOR OR RACE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR	
<u>Female</u>	<u>Negro</u>		<u>May 12, 1913</u>	<u>46</u>	Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY	
<u>Housewife</u>		<u>--</u>		<u>Forest City, Ark.</u>		<u>U. S. A.</u>	
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE	
<u>Caleb Bowers</u>			<u>Sylvia Crawford</u>			<u>Toby Deere</u>	
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		
<u>No</u>			<u>--</u>		<u>Glendora Garrett 4324 St. Ferd</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Intracerebral hemorrhage (R parietal-temporal lobe) 2 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) Hypertensive cardiovascular disease 2 years or more

DUE TO (c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic congestion of lungs and liver

PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

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.)	
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 7-11-1959 to 7-12-1959 and last saw her alive on 7-13-1959
 Death occurred at 5:15 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
<u>Ronald C. Passmore, M.D.</u>	<u>601 S. Brentwood Clayton</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY
<u>Removal</u>	<u>7/17/59</u>	<u>Forest City, Arkansas</u>
23d. LOCATION (City, town, or county) (State)	24. FUNERAL DIRECTOR ADDRESS	
	<u>Charles J. Gates 4107 Finney</u>	

25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
<u>7-16-59</u>	<u>John C. Murphy, MD</u>

(Licensed Embalmer's Statement on Reverse Side)

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. 1825

P. O. Address 4107 Finney Av

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his OWN HANDWRITING. (Failure to conform 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.