

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027466

FILED VS AUG 10 1959

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2064 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. 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 1b <u>3 DAYS</u>	c. CITY OR TOWN <u>Kinloch</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 <u>St. Louis Co. Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>139 MacArthur</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Fannie</u> Middle <u>Pierson</u> Last <u>Pierson</u>			4. DATE OF DEATH Month <u>7-</u> Day <u>30-</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-24-1881</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nil</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Porkstate, Miss.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Tom Dent</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>-----</u>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, <u>No</u> unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Florence Day</u>	Address <u>139 MacArthur, Kinloch, Mo.</u>
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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) <u>Congestive Heart Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months??</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart disease</u>		<u>Unknown</u>
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Emphysema, pernicious anemia - Generalized arteriosclerosis</u>		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
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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 <u> </u> Month, Day, Year <u> </u> p.m. <u> </u>		

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 <u> </u> COUNTY <u> </u> STATE <u> </u>
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21. I attended the deceased from 7-27-1959 to 7-30-1959 and last saw her her alive on 7-30-1959
Death occurred at 6:05 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Paul W. Schepher M.D.</u>	22b. ADDRESS <u>601 So. Brentwood Blvd.</u>	22c. DATE SIGNED <u> </u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/3/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>
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24. FUNERAL DIRECTOR <u>G. Wade Grabber</u>	ADDRESS <u>4202 Finney Avenue</u>	25. DATE RECD. BY LOCAL REG. <u>8-1-59</u>	REGISTRAR'S SIGNATURE <u>J. M. [Signature]</u>
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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 Edward G. Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 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.