

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027536

FILED VS AUG 1 0 1959

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 2073

DED

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u>		Length of stay in 1b <u>5hrs</u>	c. CITY OR TOWN <u>Fenton</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>512 Water St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Ray</u> Middle <u>W.</u> Last <u>White</u>			4. DATE OF DEATH Month <u>8</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6.12/1905</u>	9. AGE (last birthday) <u>54</u>	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) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tool & Die</u>	11. BIRTHPLACE (City and state or country) <u>Herrin Ill</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>Benjamin Guido</u>		13b. MOTHER'S MAIDEN NAME <u>Vincenva Digerlando</u>		14. NAME OF HUSBAND OR WIFE <u>Thelma White</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. <u>497-07-0078</u>	17. INFORMANT <u>Thelma White</u> Address <u>512 Water St.</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) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Benign Essential Hypertension</u> <u>1 yr.</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)	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
---	--

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 _____ Month, Day, Year _____ a.m. _____ p.m. _____	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 may 5, 59 to aug 1, 59 and last saw him alive on aug 1, 59
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Michael Sulick M.D.</u>	22b. ADDRESS <u>9012 Manchester Av</u>	22c. DATE SIGNED <u>8-3-59</u>
--	---	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/4/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>
--	----------------------------	---	---

24. FUNERAL DIRECTOR <u>Leslie Fisher</u> ADDRESS <u>Fenton Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8-3-59</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
--	---	---

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 Samuel J. Mahoney

Licensed Embalmer No. 432

P. O. Address Albany

- 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.