

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027708

FILED VS AUG 7 1959

DED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2009 STATE FILE NUMBER

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Koch, Missouri | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 6 days | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Robert Koch Hosp. | | d. STREET ADDRESS City Hosp. Work House 4200 S. Broadway | |
| 3. NAME OF DECEASED (Type or print) Charles | | 4. DATE OF DEATH Month July Day 7 Year 59 | |
| 5. SEX Male | | 6. COLOR OR RACE non-white | |
| 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 9-9-96 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nil | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (City and state or country) Missouri | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Charles Lowe | | 13b. MOTHER'S MAIDEN NAME ? | |
| 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. None | |
| 17. INFORMANT Frank Pearson | | Address 2328 Pine | |

| | | |
|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis | | INTERVAL BETWEEN ONSET AND DEATH 2 hrs.? |
| DUE TO (b) Cerebra-arteriosclerosis | | |
| DUE TO (c) 332X | | |
| 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 _____ 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 7-1-59 to 7-7-59 and last saw her/him alive on 7-7-59 Death occurred at 7:45 A m on the date stated above, and to the best of my knowledge, from the causes stated. | | |
| 22a. SIGNATURE (Degree or title) Bernard Friedman M.D. | | 22b. ADDRESS Robert Koch Hosp. Koch, Mo. |
| 22c. DATE SIGNED 7-7-59 | | |
| 23a. BURIAL, CREMATION, or other disposal Rowland-Aker Mortuary Service | 23b. DATE 7-8-59 | 23c. NAME OF CEMETERY OR CREMATORY ANATOMICAL |
| 23d. LOCATION (City, town, or county) (State) ST Louis, MO. | | |
| 24. FUNERAL DIRECTOR ADDRESS 4104 Manchester Ave. St. Louis 10, Mo. | | 25. DATE RECD. BY LOCAL REG. 7-28-59 |
| 26. REGISTRAR'S SIGNATURE John C. Murphy M.D. | | |

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.