

VISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030224

VS SEP 4 1959

2 7886

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>ST. LOUIS, MO.</b>                     |  | a. STATE <b>Missouri</b> b. COUNTY  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1.</b> |  | c. CITY OR TOWN <b>St. Louis</b>  |  |
| Length of stay in 1b   |  | d. STREET ADDRESS (If outside, give location) <b>3927 Blair</b>                       |  |
| Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>   |  | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>               |  |

|                                     |                      |        |                   |                  |                     |               |                  |
|-------------------------------------|----------------------|--------|-------------------|------------------|---------------------|---------------|------------------|
| 3. NAME OF DECEASED (Type or print) | First <b>CHARLES</b> | Middle | Last <b>BAKER</b> | 4. DATE OF DEATH | Month <b>AUGUST</b> | Day <b>21</b> | Year <b>1959</b> |
|-------------------------------------|----------------------|--------|-------------------|------------------|---------------------|---------------|------------------|

|  |                               |   |                                    |  |  |  |
|--|-------------------------------|---|------------------------------------|--|--|--|
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <b>11-29-1898</b> | 9. AGE (last birthday) <b>60</b>                           | IF UNDER 1 YEAR<br>Months _____ Days _____ | IF UNDER 24 HR<br>Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unk</b> |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>unk</b>  |                                    | 11. BIRTHPLACE (City and state or country) <b>Missouri</b> | 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>  |  |

|  |  |                             |
|--|--|-----------------------------|
| 13a. FATHER'S NAME <b>Joseph Baker</b> | 13b. MOTHER'S MAIDEN NAME <b>Catherine unk</b> | 14. NAME OF HUSBAND OR WIFE |
|--|--|-----------------------------|

|  |                                     |   |         |
|--|-------------------------------------|---|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b> | 16. SOCIAL SECURITY NO. <b>none</b> | 17. INFORMANT <b>Miss Rothwell 2331 Mullanphy</b> | Address |
|--|-------------------------------------|---|---------|

|  |  |                                  |
|--|--|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: |  | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b>   |  | <b>2 days</b>                    |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.               | DUE TO (b) <b>Arteriosclerotic Coronary Thrombosis</b> | <b>2 days</b>                    |
|  | DUE TO (c) <b>420.1</b>                                |                                  |

|   |  |
|---|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Pulmonary Fibrosis + Emphysema</b> | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 16.) |
|--|---|--|

|                     |                            |                  |
|---------------------|----------------------------|------------------|
| 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 **8-9-1959** to **8-21-1959** and last saw him alive on **8-21-1959**  
Death occurred at **8 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

|   |                                    |                                 |
|---|------------------------------------|---------------------------------|
| 22a. SIGNATURE (Ink) <b>John W. Strick M.D.</b> | 22b. ADDRESS <b>1515 Lafayette</b> | 22c. DATE SIGNED <b>8-25-59</b> |
|---|------------------------------------|---------------------------------|

|   |                            |  |   |
|---|----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> | 23b. DATE <b>8/25/1959</b> | 23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b> | 23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b> |
|---|----------------------------|--|---|

|  |  |  |
|--|--|--|
| 24. FUNERAL DIRECTOR <b>Cullen-Kelly 7267 Natural Bridge</b> | 25. DATE RECD. BY LOCAL REG. <b>AUG 24 '59</b> | 26. REGISTRAR'S SIGNATURE <b>John Smith M.D.</b> |
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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.