RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH 59-030354

FILED VS SEP 1 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 7731 STATE FILE NUMBER

DED

1. PLACE OF DEATH
a. COUNTY

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

c. CITY OR TOWN St. Louis | Inside Limits Yes ☐ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Homer G. Phillips | Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 3112 Sheridan | Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Middle Last Douthit

4. DATE OF DEATH Month 8 Day 11 Year 59

5. SEX Male

6. COLOR OR RACE Negro

7. Married ☐ Never Married ☑ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 8-11-59

9. AGE (last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours 2 Min. 42

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) Saint Louis, Missouri

12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME —

13b. MOTHER'S MAIDEN NAME Myrtle Douthit

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) —

16. SOCIAL SECURITY NO. —

17. INFORMANT Hospital Records. Address 2601 N. Whittier

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY: | INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Premature birth, Neonatal death

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c) 773.5

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. ☐ Yes ☑ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 8-11-59, to 8-11-59 and last saw him alive on 8-11-59

Death occurred at 5:05 a. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Park J White, MD.

22b. ADDRESS 2601 N. Whittier

22c. DATE SIGNED 8-11-59

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE 8-31-59

23c. NAME OF CEMETERY OR CREMATORY Anatomical Board

23d. LOCATION (City, town, or county) (State) St. Louis, Mo.

24. FUNERAL DIRECTOR Rowland Mortuary Svc. ADDRESS 4104-06 Manchester

25. DATE REC'D BY LOCAL REG. AUG 2 0 59

26. REGISTRAR'S SIGNATURE Earl Smith, M.D. R.P.

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

DOCUMENT

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 m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____
Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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