

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030433

FILED VS SEP 1 1959

2 7702

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY _____ | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY _____ | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 9 wks. | c. CITY OR TOWN St. Louis, MO Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp. | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 2821 Lawton Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

| | | | | | |
|---|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First Mamie Middle _____ Last Green | | | 4. DATE OF DEATH Month 8 Day 17 Year 59 | | |
|---|--|--|--|--|--|

| | | | | | | |
|--------------------------------|--|---|---|--|---|---|
| 5. SEX female | 6. COLOR OR RACE col. | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 18, 1899 | 9. AGE (last birthday) 59 years | 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) Unemployed | 10b. KIND OF BUSINESS OR INDUSTRY 66----- | 11. BIRTHPLACE (City and state of country) St. Louis Mo | 12. CITIZEN OF WHAT COUNTRY U. S. A. |
|---|--|--|---|

| | | |
|---|--|---|
| 13a. FATHER'S NAME Richard Green | 13b. MOTHER'S MAIDEN NAME Nellie Mae Temple | 14. NAME OF HUSBAND OR WIFE Deceased |
|---|--|---|

| | | | |
|---|---|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Velma Lee | Address 4287 St. Louis Avenue |
|---|---|--|--|

| | | |
|--|--------------------------------------|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma of Bile Ducts</i> | | INTERVAL BETWEEN ONSET AND DEATH 9 weeks. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) _____ DUE TO (c) _____ | 155.1 |

| | | |
|--|--|---|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Left Middle Cerebral Artery Thrombosis</i> | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 6-10-59 , to 8-17-59 and last saw her him alive on 8-17-59
 Death occurred at 6:10 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

| | | | |
|---|-------------------------|--|---|
| 22a. SIGNATURE <i>John W. Beckham, M.D.</i> | (Degree or title) _____ | 22b. ADDRESS 5800 Arsenal | 22c. DATE SIGNED 8/18/59 |
|---|-------------------------|--|---|

| | | | |
|--|------------------------------------|--|--|
| 23. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 8/21/59 | 23c. NAME OF CEMETERY OR CREMATORY Father Dickson | 23d. LOCATION (City, town, or county) (State) St. Louis County, Mo. |
|--|------------------------------------|--|--|

| | | | |
|---|---------------------------------|---|---|
| 24. FUNERAL DIRECTOR E.B. Kooner | ADDRESS 1221 N. Grand | 25. DATE RECD. BY LOCAL REG. AUG 19 1959 | 26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i> |
|---|---------------------------------|---|---|

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 Melvin Blackburn

Licensed Embalmer No. 396

P. O. Address 1221 N. D.

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.