

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# 59-030489

FILED VS AUG 27 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 2 7627 STATE FILE NUMBER

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 <u>St. Louis</u>		Length of stay in 1b	c. CITY OR TOWN <u>St. Louis</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>Faith Hospt.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2226 a Warren St.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>Elaine Ann Hinnah (Nelms)</u>			4. DATE OF DEATH Month <u>8</u> Day <u>15</u> Year <u>59</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>4/8/1939</u>	9. AGE (last birthday) <u>20</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Credit Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Biedermans Furn. St. Louis</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Joseph B. Hinnah</u>		13b. MOTHER'S MAIDEN NAME <u>Mildred C. Ellebrecht</u>		14. NAME OF HUSBAND OR WIFE <u>Lanny E. Nelms</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>496-38-3736</u>		17. INFORMANT Address <u>Mrs. Hinnah 2226 A Warren St.</u>	

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) <u>Meningitis</u>			<u>1 mo</u>
DUE TO (b) <u>Pl. Total Basilar Pneumonia</u>			<u>1 mo</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 checked="" 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 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 7/3/59 to 8/15/59 and last saw her alive on 8/15/59  
Death occurred at 1:30 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>1901 Madison St</u>	22c. DATE SIGNED <u>8/17/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8/18/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>
24. FUNERAL DIRECTOR <u>Robert D. Kinealy 2228 St. Louis Ave.</u>		23d. LOCATION (City, town, or county) <u>St. Louis Co. Mo.</u>

25. DATE RECD. BY LOCAL REG. <u>AUG 17 59</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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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

*Gustav W. Dichter*

Licensed Embalmer No. *433*

P. O. Address *St. Louis*

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.