

**R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS AUG 27 1959

2 7570 59-030581

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 <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4560 N. Market</b>		
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle Last <b>Lee</b>			4. DATE OF DEATH Month <b>8</b> Day <b>2</b> Year <b>59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6 June 1887</b>	9. AGE (last birthday) <b>72</b>	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) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>retired</b>		11. BIRTHPLACE (City and state or country) <b>Mississippi</b>		
12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>		13a. FATHER'S NAME <b>unk.</b>		13b. MOTHER'S MAIDEN NAME <b>unk.</b>		
14. NAME OF HUSBAND OR WIFE <b>X X X X X</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>X</b>		
17. INFORMANT <b>M Ferry</b>		Address <b>4560 NO. Market</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Brain Syndrome due to Arteriosclerosis Diabetes Mellitus</b>				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 Month, Day, Year a.m. p.m.		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 <b>8-11-59</b> to <b>8-12-59</b> and last saw <b>her</b> alive on <b>8-12-59</b> Death occurred at <b>1:20</b> <b>P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <b>Sydney A. Graw, M.D.</b>			22b. ADDRESS <b>2601 N. Whittier St.</b>		22c. DATE SIGNED <b>8-14-59</b>	
23a. BURIAL, CREATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>15 Aug. 59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Terrill</b>		23d. LOCATION (City, town, or county) (State) <b>Arkansas</b>	
24. FUNERAL DIRECTOR <b>Reliable Funeral Sys. 1389 N. Union</b>		ADDRESS		25. DATE RECD. BY LOCAL REG. <b>AUG 15 59</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>	

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

*John K. Cuern...*

Licensed Embalmer No. 4470

P. O. Address 2405 N

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.