

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-030893

STATE FILE NUMBER

FILED VS AUG 24 1959

Registrar's No. 7362

Registration District No. Primary Registration District No.

S. 300

v. 1-57

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases of Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>1</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>City Hospital No. 1</i>		Length of stay in lb <i>35 yrs</i>	d. STREET ADDRESS (If outside, give location) <i>1319^a Carr St.</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>Rosa White</i>			4. DATE OF DEATH Month Day Year <i>8 5 59</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-6-1893</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	9. AGE (In years at birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <i>60</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (City and state or country) <i>Anquilla Miss. U.S.A.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13a. FATHER'S NAME <i>George Flowers</i>		13b. MOTHER'S MARDEN NAME <i>Anna Towns</i>	14. NAME OF HUSBAND OR WIFE <i>Lucius White</i>
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 Address <i>Lucius White 1319^a Carr</i>
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>Anterior Myocardial Infarction</i>			INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs.</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <i>420.1</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <i>Oct 11, 1953</i> to <i>August 5, 1959</i> and last saw her alive on <i>August 4, 1959</i> Death occurred at <i>8:30 A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Chas. F. Forde, M.D.</i> (Degree or title) M.D.		22b. ADDRESS <i>2801 N. Taylor Ave.</i>	22c. DATE SIGNED <i>Aug 7, 1959</i>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Rem</i>	23b. DATE <i>8-10-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Father Dickson Cem.</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis Mo.</i>
24. FUNERAL DIRECTOR ADDRESS <i>Manuel Undertaking Co. 1711 N. Taylor</i>		25. DATE RECD. BY LOCAL REG. <i>AUG 7 '59</i>	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D. mjb</i>

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *W. Claude Gord*

Licensed Embalmer No. *3489*

P. O. Address *1123 N. J.*

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.