

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030935

FILED VS SEP 8 1959

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2240 STATE FILE NUMBER

IDED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
a. COUNTY <u>Saint Louis</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) <u>CLAYTON</u> OR TOWN <u>Kinloch</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>Saint Louis</u>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>D.O.A. COUNTY HOSPITAL</u>		Length of stay in 1b <u>DOA</u> <u>10 yrs</u>		c. CITY OR TOWN <u>Kinloch</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1051 Scott</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH				
First <u>Lena</u>		Middle		Last <u>Cook</u>		Month <u>8</u> Day <u>18</u> Year <u>59</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>7/24/1912</u>		
				9. AGE (last birthday) <u>47</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Unk.</u>			13b. MOTHER'S MAIDEN NAME <u>Unk.</u>			14. NAME OF HUSBAND OR WIFE <u>W. Cook</u>		
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. <u>496-40-4913</u>		17. INFORMANT <u>Lorenzo Perkins (GS)</u> Address <u>1925a Cora St. Louis</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>Unknown Natural Causes</u>								
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								
DUE TO (b)								
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 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>John C. Murphy M.D. Acting Health Commissioner</u>				22b. ADDRESS <u>801 S. Brentwood Clayton, Mo.</u>		22c. DATE SIGNED		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8/24/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park Cem. St. Louis Co., Mo.</u>		23d. LOCATION (City, town, or county) (State)		
24. FUNERAL DIRECTOR <u>Boyd Mothers 441 Lix, Kinloch, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>8-19-59</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>		

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 Edward A. Flynn

Licensed Embalmer No. 444

P. O. Address Kinlock, N.Y.

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.