

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS SEP 8 1959

59-030955

DED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2350 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis,</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis.</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton, Mo.</u>		Length of stay in 1b <u>1 Mo.</u>	c. CITY OR TOWN <u>Maplewood</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis County Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>7604 Rannels</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Hulen</u> Middle <u>R.</u> Last <u>loyd</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>30,</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>9/27/1883</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Orderly</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Koch Hospital</u>	11. BIRTHPLACE (City and state or country) <u>Calloway Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James F. Loyd</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Wilkerson</u>		14. NAME OF HUSBAND OR WIFE <u>Unknown</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>Nil.</u>	17. INFORMANT <u>James W. Loyd, 4982 Pernod, Ave. St. Louis, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
DUE TO (b) <u>ACUTE Pyelonephritis ± Abscess formation</u> <u>± kidney</u>		<u>1 month.</u>
DUE TO (c) <u>Chronic Pyelonephritis ± hydrocephalus</u>		<u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>focal Atelectasis secondary to obstruction.</u>		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 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 7/31/59 to 8-30-59 and last saw her/him alive on 8-30-59
 Death occurred at 5Pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Donald C. Gamm MA</u>	22b. ADDRESS <u>St. Louis County Hospital</u>	22c. DATE SIGNED <u>8-30-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9-1-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>White Cloud Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Fulton, Mo.</u>
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24. FUNERAL DIRECTOR <u>Albert H. Hoppe Inc. 4700 Washington, Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>8-31-59</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</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 Elton R. Remick

Licensed Embalmer No. 4283

P. O. Address H. Lane

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.