RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–031009

STATE FILE NUMBER

FILED VS AUG 26 1959

Registration District No. 517 Primary Registration District No. 547 Registrar's No. 2165

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights — Length of stay in 1b: 1 day
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital — Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis
c. CITY OR TOWN FENTON ~~Richmond Heights~~ — Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) ~~St. Mary's Hospital~~ — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First John, Middle Steven, Last KING
4. DATE OF DEATH: Month August, Day 11, Year 1959
5. SEX: male
6. COLOR OR RACE: white
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 8/10/1959
9. AGE (last birthday) — IF UNDER 1 YEAR: Months, Days 1 — IF UNDER 24 HR: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -----
10b. KIND OF BUSINESS OR INDUSTRY: -----
11. BIRTHPLACE (City and state or country): St. Louis Co., Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: William R King
13b. MOTHER'S MAIDEN NAME: Joan C Ellrich
14. NAME OF HUSBAND OR WIFE: -----
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: William R King — Address: Fenton, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congenital Pulmonary Atelectasis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Premature Birth
DUE TO (c) Unknown
INTERVAL BETWEEN ONSET AND DEATH
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 8/10/1959, to 8/11/1959 and last saw her/him alive on 8/11/1959
Death occurred at 1 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Thomas Miles M.D.
22b. ADDRESS 6420 Clayton Rd.
22c. DATE SIGNED 8/11/59

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 8-12-59
23c. NAME OF CEMETERY OR CREMATORY St. Pauls Church Yd.
23d. LOCATION (City, town, or county) (State) ST. LOUIS Co. MO.

24. FUNERAL DIRECTOR John L Ziegenhein & Sons — ADDRESS 7027 Gravois
25. DATE RECD. BY LOCAL REG. 8-12-59
26. REGISTRAR'S SIGNATURE John E Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF — DOCUMENT

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 no embalming, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed W D Wester

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to cor
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.