URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS OCT 8 1959

59-033537

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 8987

ENDED

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Mo.

Length of stay in 1b: 17 yrs. 1 Mo. 11 days

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Louis State Hospital

Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE

b. COUNTY

c. CITY OR TOWN: St. Louis, Mo.

Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location): 2818 Cherokee St.

Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First CHARLES Middle EDWARD Last BALDWIN

4. DATE OF DEATH: Month Sept. Day 28, Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 1-12-1889

9. AGE (last birthday): 70 yrs.

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): formerly: Painter

10b. KIND OF BUSINESS OR INDUSTRY: Painting

11. BIRTHPLACE (City and state or country): Pittsburgh, Pa.

12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME: George Baldwin

13b. MOTHER'S MAIDEN NAME: Nora (Lovejoy) Baldwin

14. NAME OF HUSBAND OR WIFE: Frances Baldwin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 488-09-5133

17. INFORMANT: Frances Baldwin, 6521 Woodrow Ave., 20

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): General Paralysis of Insane

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Lues (acquired)

DUE TO (c): .025 X

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 Aug. 17, 1942, to Sept. 28, 1959 and last saw her/him alive on Sept. 28, 1959

Death occurred at 4:40 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): R. L. Hofstatter, M.D.

22b. ADDRESS: 5400 Arsenal St.

22c. DATE SIGNED: 9-29-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: Oct. 1, 1959

23c. NAME OF CEMETERY OR CREMATORY: Valhalla Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis County, Missouri

24. FUNERAL DIRECTOR ADDRESS: CALVIN F. FEUTZ, 4828 NAT'L. BRIDGE BLVD.

25. DATE RECD. BY LOCAL REG.: SEP 30 59

26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 me

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Ralph C. Linders

Signature of Student Embalmer

Licensed Embalmer No. 4275

P. O. Address St. Louis

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