

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033758

FILED VS OCT 8 1959

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 2-8872

ENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO</u>		Length of stay in 1b		c. CITY OR TOWN <u>St. Louis, Missouri</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP. #1.</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2727 Spruce Street</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>DUNNIEHIGH</u> Last				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>25</u> Year <u>1959</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2/5/1899</u>		9. AGE (last birthday) <u>60</u>		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) <u>Porter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Printing Company</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>					
13a. FATHER'S NAME <u>Charles Dunniehigh</u>				13b. MOTHER'S MAIDEN NAME <u>Lucy</u>				14. NAME OF HUSBAND OR WIFE <u>Artemese Dunniehigh</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>489-09-8539</u>		17. INFORMANT <u>Artemese Dunniehigh</u>				Address <u>2727 Spruce</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>UREMIA</u>													
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CHRONIC PYELONEPHRITIS</u>													
DUE TO (c) _____										<u>6000</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CHRONIC OBSTRUCTIVE EMPHYSEMA</u>								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <u>9/18/59</u> to <u>9/25/59</u> and last saw her/him alive on <u>9/25/59</u> Death occurred at <u>8:14 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Nicholas Owen M.D.</u>						22b. ADDRESS <u>1515 LAFAYETTE AVE.</u>				22c. DATE SIGNED <u>9/25/59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/1/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>					
24. FUNERAL DIRECTOR <u>E. B. Keane</u>				ADDRESS <u>1221 N. Grand Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>SEP 26 59</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith 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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Clarence Speed

Licensed Embalmer No. 4755

P. O. Address 1221 N 8

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.