

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034019

FILED VS. SEP 21 1959

2 8357

STATE FILE NUMBER

INDEXED

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

68

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>St. Louis 2</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis 240</i>		Length of stay in 1b		c. CITY OR TOWN <i>St. Louis 2</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>3127 Locust St</i>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>3127 Locust St</i>	
3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>Lawrence</i> Last <i>Lawrence</i>				4. DATE OF DEATH Month <i>8</i> Day <i>13</i> Year <i>1959</i>			
5. SEX <i>Male</i>		6. COLOR OF HAIR <i>Black</i>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (at birth) Months <i>87</i> Days <i>13</i> Hours <i>13</i> Min. <i>49</i>		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)	
10a. <i>None</i>		10b. <i>None</i>		11. <i>Mo</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13a. FATHER'S NAME <i>Walt</i>				13b. MOTHER'S MAIDEN NAME <i>Walter</i>		14. NAME OF HUSBAND OR WIFE <i>Walter</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>D.C. Taylor</i> Address <i>1300 Clark</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO (b) <i>Arteriosclerotic</i> DUE TO (c) <i>420.0 Heart Disease</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Arteriosclerosis</i>						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 of) <i>Paul Simon</i> Deputy Registrar				22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>9/2/59</i>	
23a. BURIAL, CREMATION, or REMOVAL (Specify)		23b. DATE <i>9-30-59</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Anatomical Board</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>	
24. FUNERAL DIRECTOR <i>Rowland Aker Mortuary Service</i> ADDRESS <i>4104 Manchester Ave. St. Louis 10, Mo.</i>				25. DATE RECD. BY LOCAL REG. <i>SEP 10 1959</i>		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>	

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.