

MORTUARY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 16 1959

59-034317

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7915**

UNRECORDED

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo. Length of stay in lb _____ c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri. b. COUNTY _____ c. CITY OR TOWN St. Louis. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 2217 St. Louis, Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First Sheron Middle Ann Last Sett			4. DATE OF DEATH Month August Day 26 Year 1959		
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1956	9. AGE (last birthday) 2	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Corinth, Mississippi	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME William Sett	13b. MOTHER'S MAIDEN NAME Mary Ann Young	14. NAME OF HUSBAND OR WIFE Nil.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.	16. SOCIAL SECURITY NO. Nil.	17. INFORMANT Address William Sett, 2217 St. Louis, Ave.
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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) Lobar Pneumonia, left lower lobe. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) 490X		INTERVAL BETWEEN ONSET AND DEATH _____
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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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.)
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20c. TIME OF INJURY Hour _____ a.m. / p.m. Month, Day, Year _____	_____
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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
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____.
 Death occurred at _____ **445 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deputy or title) Patrick Taylor Caravel	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 8-26-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-27-59	23c. NAME OF CEMETERY OR CREMATORY Local	23d. LOCATION (City, town, or county) (State) Corinth, Mississippi
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24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe Inc., 4700 Washington Blvd.	25. DATE RECD. BY LOCAL REG. AUG 26 59	26. REGISTRAR'S SIGNATURE Lead Smith, M.D.
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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 J. W. Dinkley
Licensed Embalmer No. BE
P. O. Address J. W. Dinkley

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.