

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034375

FILED VS SEP 21 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 8353**

MAILED

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| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo. | | Length of stay in 1b | c. CITY OR TOWN ST. LOUIS, MO. | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp. #1 | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 3005 CAROLINE | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last Baby Girl Sturdivant | | | 4. DATE OF DEATH Month Day Year 8 - 2 - 59 | | |
| 5. SEX FEMALE | 6. COLOR OR RACE NEGRO | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 8/1/59 | 9. AGE (last birthday) IF UNDER YEAR IF UNDER 24 HR Months Days Hours Min. 15 16 | |
| 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) ST. LOUIS, MO | 12. CITIZEN OF WHAT COUNTRY U.S.A | |
| 13a. FATHER'S NAME COOZY STURDIVANT | | 13b. MOTHER'S MAIDEN NAME TONAFARMER | | 14. NAME OF HUSBAND OR WIFE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If no, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NONE | 17. INFORMANT Address ST. LOUIS CITY HOSP. #1 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) atelectasis | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) _____ DUE TO (c) _____ 7620 | | | | | |
| 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 8-1-59 to 8-2-59 and last saw her live on 8-2-59 Death occurred at 9:15A m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22. SIGNATURE (Degree or title) R James Vaccarella, M.D. | | 22b. ADDRESS 1515 Lafayette Ave. | | 22c. DATE SIGNED 8-2-59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) 9-30-59 | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY Anatomical Board | 23d. LOCATION (City, town, or county) (State) St. Louis, Mo. | | |
| 24. FUNERAL DIRECTOR Rowland Aker 410 Manchester | ADDRESS | 25. DATE REC'D BY LOCAL REG. SEP 10 1959 | 26. REGISTRAR'S SIGNATURE Loan Smith, M.D. | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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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.