

U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034414

FILED VS SEP 21 1959

STATE FILE NUMBER

Registration District No.

Primary Registration District No.

Registrar's No.

2 8202

ENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Desloge			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2618 Park			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Sinclair Tousey				4. DATE OF DEATH Month Day Year Sept. 3 1959			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3/15/1874	9. AGE (last birthday) 85	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) Tobacco Wrapper Office			10b. KIND OF BUSINESS OR INDUSTRY Tobacco Ind.	11. BIRTHPLACE (City and state or country) Venice Ill.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Unkown Tousey			13b. MOTHER'S MAIDEN NAME Unk			14. NAME OF HUSBAND OR WIFE Mary Noonan	
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. 495-40-2447		17. INFORMANT Address Mary Tousey 2618 Park			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> DUE TO (b) <i>Bronchogenic Carcinoma</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>9 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Cancer of Prostate</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 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 Month, Day, Year a.m. p.m.							
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 <i>Feb 1959</i> to <i>Sept 3 1959</i> and last saw her <i>Sept 3 1959</i> Death occurred at <i>2:30 p.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>James C Redington M.D.</i>				22b. ADDRESS <i>Clayton, Mo 950 Francis Place</i>		22c. DATE SIGNED <i>9-4-59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>9/8/1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvary</i>		23d. LOCATION (City, town, or county) <i>St. Louis</i>		23e. (State) <i>Mo.</i>	
24. FUNERAL DIRECTOR ADDRESS <i>E. J. Schnur 3125 Lafayette Ave</i>				25. DATE RECD. BY LOCAL REG. <i>SEP 4 1959</i>	26. REGISTRAR'S SIGNATURE <i>Kean Smith, M.D.</i> <i>S.P.</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 Thomas R. Lewicki

Licensed Embalmer No. 3793

P. O. Address 3125 Twp

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.