

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034488

FILED VS OCT 15 1959

STATE FILE NUMBER

28795

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

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| 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 Saint Louis | | Length of stay in 1b 8 years | c. CITY OR TOWN Saint Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR On bus at Florissant, INSTITUTION Jennings Avenue | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1416 Franklin Avenue Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First John Middle Whitfield Last | | | 4. DATE OF DEATH Month 8 Day 28 Year 1959 | | |
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|-----------------------|------------------------------------|---|-------------------------------------|---|--------------------------------------|------------------------|
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 1-1-1911 | 9. AGE (last birthday) 48 yrs | IF UNDER 1 YEAR Months Days Hours | IF UNDER 24 HR Min. |
|-----------------------|------------------------------------|---|-------------------------------------|---|--------------------------------------|------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Aberdeen, Mississippi | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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| 13a. FATHER'S NAME Louis Whitfield | 13b. MOTHER'S MAIDEN NAME Leana Robinson | 14. NAME OF HUSBAND OR WIFE Beatrice Whitfield |
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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. 425-07-5516 | 17. INFORMANT Joseph L. Tucker-5653 Vernon |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Coronary Sclerosis DUE TO (c) 420.1 | | INTERVAL BETWEEN ONSET AND DEATH |
| 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 _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <i>Joseph L. Tucker</i> | (Deceased or title) | 22b. ADDRESS 1306 Clark | 22c. DATE SIGNED 10/2/59 |
|---|---------------------|-----------------------------------|------------------------------------|

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|--|-------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 10-3-1959 | 23c. NAME OF CEMETERY OR CREMATORY Father Dixon Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri |
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| 24. FUNERAL DIRECTOR Gus Lowe - 2930 Dickson Street | 25. DATE RECD. BY LOCAL REG. 9-24-1959 | 26. REGISTRAR'S SIGNATURE Paul 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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Leroy W. Bannister

Licensed Embalmer No.

4523

P. O. Address

4151 Washington

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.