

UNIVERSITY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037349

FILED VS NOV 10 1959

Registration District No. 316 Primary Registration District No. Registrar's No. 419 STATE FILE NUMBER

RECEIVED

1. PLACE OF DEATH a. COUNTY St. Francois				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cape Girardeau			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Francois Township		Length of stay in 1b 20 Y; 7M; 25 D		c. CITY OR TOWN Cape Girardeau		Reside on Farm Unknown Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital No. 4			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Unknown Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First THOMAS Middle PINKSTON Last PINKSTON				4. DATE OF DEATH Month October Day 27 Year 1959			
5. SEX Male	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 Abt. 1892	9. AGE (last birthday) Abt. 67	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY Cape Girardeau Co., Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Unknown			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE	
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. None		17. INFORMANT Address Records, State Hospital No. 4, Farmington, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis - - - - - INTERVAL BETWEEN ONSET AND DEATH 24 hrs.							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Coronary Sclerosis - - - - - Unknown.							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Mental deficiency (idiot), with epilepsy.					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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 June 1, 1953 to Oct. 27, 1959 and last saw him <input checked="" type="checkbox"/> live on Oct. 27, 1959 Death occurred at 10:30 P. M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>John C. Brennan M.D.</i> (Degree or title)			22b. ADDRESS State Hospital No. 4 Farmington, Missouri			22c. DATE SIGNED 1-4-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Oct. 28, 1959	23c. NAME OF CEMETERY OR CREMATORY Anatomy Dept. Washington Univ. Med. School, St. Louis, Mo.		23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR Cozean Funeral Home, Farmington, Mo. ADDRESS		25. DATE RECD. BY LOCAL REG. Nov. 4, 1959		26. REGISTRAR'S SIGNATURE <i>Cather Andloff</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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

NOT EMBALMED

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.