

# MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037467

FILED OCT 23 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

2 9302

STATE FILE NUMBER

UNDECEASED

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b> Length of stay in lb <b>45 yrs</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY _____  c. CITY OR TOWN <b>ST. LOUIS</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  d. STREET ADDRESS (If outside, give location) <b>III18, Rear No. 10th ST.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>LUCILLE CANNON</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>10 / 8 / 1959</b>				
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>COL.</b>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>5/1/1893</b>	<b>9. AGE (last birthday)</b> <b>66</b>	IF UNDER 1 YEAR Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>DOMESTICTS</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>DELTA LOUISEANA</b>			
<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A</b>		<b>13a. FATHER'S NAME</b> <b>JOHN WATSON</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>UNKNOWN</b>			
<b>14. NAME OF HUSBAND OR WIFE</b> <b>UNKNOWN</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>?</b>			
<b>17. INFORMANT</b> <b>ELLA TURNER</b>		<b>17. ADDRESS</b> <b>IO18A, No. 10 th St</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Breuchs pneumonia</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ } DUE TO (c) _____			
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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)			
<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>		<b>STATE</b>			
<b>21. I attended the deceased from _____ to _____ and last saw her/him alive on _____</b> Death occurred at <b>1245 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> <i>John M. Smith</i> (Degree or title)			<b>22b. ADDRESS</b> <b>1300 Clark</b>		<b>22c. DATE SIGNED</b> <b>10/10/59</b>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>REMOVAL</b>		<b>23b. DATE</b> <b>10 / 12 / 59</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>WASHINGTON PARK CEMETERY</b>			
<b>23d. LOCATION</b> (City, town, or county) <b>ST. LOUIS MO. MISSOURI</b>		<b>24. FUNERAL DIRECTOR'S ADDRESS</b> <b>2812, THOMAS STREET</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>OCT 1 0 59</b>			
<b>26. REGISTRAR'S SIGNATURE</b> <i>John M. Smith</i>		<b>26. REGISTRAR'S SIGNATURE</b> <b>John M. Smith, M.D.</b>					

DOCUMENT

MEDICAL CERTIFICATION

BY APPROVIT OF

S.P.

**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. 4441

P. O. Address 2012 Thom

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.