

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS NOV 3 1959

2 9758 59-037572
 STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 7 yrs. 3 mo.		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 Chronic Hosp.			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3117 Hickory St.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Nathaniel Middle Last Facon				4. DATE OF DEATH Month 10 Day 21 Year 59									
5. SEX Male		6. COLOR OR RACE Col.		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Sep ^r divorced <input type="checkbox"/>		8. DATE OF BIRTH 5-5-97		9. AGE (last birthday) 62		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) none				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and state or country) Dublin, Georgia			12. CITIZEN OF WHAT COUNTRY U.S.A.				
13a. FATHER'S NAME unk.				13b. MOTHER'S MAIDEN NAME Sarah Foster				14. NAME OF HUSBAND OR WIFE none					
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. ?		17. INFORMANT Address Jennie Johnson 3117 Hickory							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia										INTERVAL BETWEEN ONSET AND DEATH 12 days			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 491x													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Arteriosclerosis - 7 yrs.								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 _____ 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 7-18-52 to 10-21-59 and last saw ^{her} him alive on 10-21-59 Death occurred at 7:55 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) John W. Beckham, M.D.						22b. ADDRESS 5800 Arrend			22c. DATE SIGNED 10/22/59				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10/26/59		23c. NAME OF CEMETERY OR CREMATORY Father Dixon				23d. LOCATION (City, town, or county) (State) St. Louis, Co., Mo.					
24. FUNERAL DIRECTOR ADDRESS Grant Johnson 4352 Wash. Blvd.					25. DATE RECD. BY LOCAL REG. OCT 24 1959			26. REGISTRAR'S SIGNATURE Loal Smith, M.D. (H.T.)					

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 F. G. Green

Licensed Embalmer No. 2963

P. O. Address 4214 Dal

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.