

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037728

FILED VS NOV 3 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 9658** STATE FILE NUMBER

INDEXED

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 4 yrs.		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) 12112 St. Louis Ave 5800 Arsenal St.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Last Johne			4. DATE OF DEATH Month 10 Day 18 Year 59				
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1870	9. AGE (last birthday) 89	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	11. BIRTHPLACE (City and state or country) Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME William		13b. MOTHER'S MAIDEN NAME Mary ?		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 Hospital Records 5800 Arsenal St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 4 yrs.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 420.0							
DUE TO (c) Generalized Arteriosclerosis						4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Decubitus Ulcer - 1 mo.					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 _____ 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 10-18-55 to 10-18-59 and last saw her/him alive on 10-18-59 Death occurred at 9:15 p.m. 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 Arsenal		22c. DATE SIGNED 10/19/59		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 10-22-59	23c. NAME OF CEMETERY OR CREMATORY City Crematory	23d. LOCATION (City, town, or county) St. Louis, Missouri				
24. FUNERAL DIRECTOR ADDRESS Frank O'Donnell 5800 Arsenal St.		25. DATE RECD. BY LOCAL REG. OCT 21 1959	26. REGISTRAR'S SIGNATURE Earl Smith, M.D. <i>mfs</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.

NOT EMBALMED **CREMATED BY CITY**

Student _____
Signature of Student Embalmer

Signed _____

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.