

DURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS NOV 12 1959

59-037829

210112

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY <i>St Louis</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY _____					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St Louis</i>		Length of stay in 1b _____		c. CITY OR TOWN <i>St Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>4302nd Fairfax</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside give location) <i>4302nd Fairfax</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>Rachel</i> Middle <i>Levela</i> Last <i>McCollum</i>				4. DATE OF DEATH Month <i>11</i> Day <i>1</i> Year <i>59</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Colored</i>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>April 13 1898</i>		9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <i>Suburban</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>St. Louis Mo</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		
13a. FATHER'S NAME <i>Albert Moore</i>			13b. MOTHER'S MAIDEN NAME <i>Elizabeth ?</i>			14. NAME OF HUSBAND OR WIFE <i>John McCollum</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, not unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>None Elizabeth Perkins 2901st Jaye</i>			Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>congestive heart failure</i> <i>arteriosclerosis</i> DUE TO (b) <i>arterio-sclerosis</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								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 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 <i>1-October</i> to <i>30-October</i> and last saw her/him alive on <i>28-October</i> Death occurred at <i>11:05 A.M.</i> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>John S. Riley, Jr. M.D.</i> (Degree or title)				22b. ADDRESS <i>4635 Easton</i>		22c. DATE SIGNED <i>1-12-59</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) _____		23b. DATE <i>11-6-59</i>		23c. NAME OF CEMETERY OR CREMATOR <i>Father Pickens Cemetery St Louis Co Mo</i>		23d. LOCATION (City, town, or county) (State) _____			
24. FUNERAL DIRECTOR <i>Helma Helen Hudson 276 Chateau</i>				25. DATE RECD. BY LOCAL REG. <i>NOV 4 1959</i>		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</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 me

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Eulton E. Culkin

Licensed Embalmer No. *1198*

P. O. Address *St. Louis*

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.