

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037838

FILED VS OCT 19 1959

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No. **2 9190**

1. PLACE OF DEATH a. COUNTY				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 checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>5157 Delmar Bl.</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>5157 Delmar Blvd.</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Amanda</i> Middle Last <i>McKown</i>				4. DATE OF DEATH Month <i>Oct.</i> Day <i>4</i> Year <i>1959</i>				
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug 24, 1888</i>	9. AGE (last birthday) <i>76</i>	IF UNDER 1 YEAR Months <i>1</i> Days <i>16</i>	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <i>Rice Saw Factory</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Making Hats</i>		11. BIRTHPLACE (City and state or country) <i>Kentucky</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>unknown</i>			13b. MOTHER'S MAIDEN NAME <i>unknown</i>			14. NAME OF HUSBAND OR WIFE <i>Leo McKown</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>498-07-8830</i>		17. INFORMANT Address <i>Florence McKurley 5155 Delmar Bl.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH <i>5 min.</i>	
IMMEDIATE CAUSE (a) <i>Medullary Failure</i>								
DUE TO (b) <i>Cerebral Anemia</i>								
DUE TO (c) <i>Renal Congestion Heart failure</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Senility</i>							PART III. If deceased was female was there a pregnancy in last 90 days. <i>434.1</i> <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.								
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>11/12/57</i> to <i>10/3/59</i> and last saw ^{her} him alive on <i>10/3/59</i> Death occurred at <i>Garfield 7:30A</i> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>Math. Elger D.O.</i> (Degree or title)				22b. ADDRESS <i>5507 Pershing</i>			22c. DATE SIGNED <i>10/6/59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Oct. 7, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Ceme</i>		23d. LOCATION (City, town, or county) <i>St. Louis</i>		23e. (State) <i>Mo</i>	
24. FUNERAL DIRECTOR <i>Buell-Campbell Mortuary</i> ADDRESS <i>5165 Delmar</i>			25. DATE RECD. BY LOCAL REG. <i>OCT 6 '59</i>		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i> <i>m & b</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

Stanley H. Dixon

Licensed Embalmer No. *4193*

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.