

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037915

FILED VS OCT 21 1959

STATE FILE NUMBER

Registration District No.

Primary Registration District No.

Registrar's No.

2-9338

UNDECEASED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>1 yr. 6 mo.</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Chronic Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>3409 Arlington</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Alfred</b> Middle Last <b>Nielsen</b>			4. DATE OF DEATH Month <b>10</b> -Day <b>8</b> -Year <b>59</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-9-74</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>85</b> IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HR
11. BIRTHPLACE (City and state or country) <b>Denmark</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>unk.</b>		13b. MOTHER'S MAIDEN NAME <b>unk.</b>	14. NAME OF HUSBAND OR WIFE <b>--</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>St. Louis Chronic Hosp 5800 Arsenal</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>17 mo.</b>
DUE TO (b) _____		
DUE TO (c) <b>Generalized Arteriosclerosis</b>		<b>17 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>420.0</b>		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 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.) <b>420.0</b>	
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 <b>5-5-58</b> to <b>10-8-59</b> and last saw her alive on <b>10-8-59</b> Death occurred at <b>9:35 p.m.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>John W. Beckham, M.D.</b>		22b. ADDRESS <b>5800 Arsenal</b>	22c. DATE SIGNED <b>10/9/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Oct. 12/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
24. FUNERAL DIRECTOR <b>Alexander &amp; Sons 6175 Delmar Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>10-10-1959</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>

(Licensed Embalmer's Statement on Reverse Side)

Dr. J. B.

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 Joseph E. McEulloch

Licensed Embalmer No. 246

P. O. Address 6134 2nd

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.