

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-037969**

**FILED VS OCT 23 1959**

**2 9389**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. \_\_\_\_\_

RECEIVED

<b>1. PLACE OF DEATH</b> a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY _____ c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>3331 Indiana</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <b>MARY</b> Middle <b>ETTA</b> Last <b>PRATHER</b>				<b>4. DATE OF DEATH</b> Month <b>OCTOBER</b> Day <b>12</b> Year <b>1959</b>									
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>9-21-1880</b>		<b>9. AGE (last birthday)</b> <b>79</b>		<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HR</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>none</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>none</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Missouri</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>					
<b>13a. FATHER'S NAME</b> <b>Joseph Prather</b>				<b>13b. MOTHER'S MAIDEN NAME</b> <b>Susan Korina</b>				<b>14. NAME OF HUSBAND OR WIFE</b> <b>-</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				<b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>17. INFORMANT</b> Address <b>Jessie Hulsey 3331 Indiana Ave.</b>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) _____ DUE TO (c) <b>260x</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)									
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>		<b>STATE</b>			
<b>21. I attended the deceased from</b> <b>Sept. 23, 1959</b> to <b>Oct. 12, 1959</b> and last saw her him alive on <b>Oct. 12, 1959</b> Death occurred at <b>3:45</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
<b>22a. SIGNATURE</b> (Degree or title) <b>James F. Egan MD</b>						<b>22b. ADDRESS</b> <b>1515 LAFAYETTE</b>			<b>22c. DATE SIGNED</b> <b>10/12/59</b>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>		<b>23b. DATE</b> <b>10-13-59</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Anthony's Cemetery</b>			<b>23d. LOCATION</b> (City, town, or county) (State) <b>Sullivan, Missouri</b>						
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Southern Funeral Home 6322 S. Grand</b>				<b>25. DATE RECD. BY LOCAL REG.</b> <b>OCT 13 '59</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Earl Smith M.D.</b>							

DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
*Revised - due to diabetes*

*20. 8. 12.*

**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 David Van Fossen

Licensed Embalmer No. 4242

P. O. Address H. Lavin M

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.