

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038162

FILED VS OCT 28 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's **2 9434** STATE FILE NUMBER

ENDED

| | | | |
|---|--|--|--|
| 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 3 days | 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 3832a Maffitt (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

| | | | | | |
|---|------------------------------------|---|--|--|---|
| 3. NAME OF DECEASED (Type or print) First Carrie Middle Last Townson | | | 4. DATE OF DEATH Month 10 -Day 11 -Year 59 | | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 7/6/1888 | 9. AGE (last birthday) 71 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (City and state or country) Valley Mines, Mo. | 12. CITIZEN OF WHAT COUNTRY U. S. A. | |
| 13a. FATHER'S NAME John Keaton | | 13b. MOTHER'S MAIDEN NAME Elizabeth ? | | 14. NAME OF HUSBAND OR WIFE Samuel Townson | |
| 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 Sanford Townson, 3832a Maffitt | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia | | INTERVAL BETWEEN ONSET AND DEATH 48 hrs. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | 491x |

| | | | |
|---|--|---|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) arteriosclerotic Heart Disease - 4 days | | 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. | 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 St. Louis, Mo. | COUNTY | STATE |
| 21. I attended the deceased from 10-7-59 to 10-11-59 and last saw her/him alive on 10-11-59 Death occurred at 9:45 p.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 10/13/59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 10/15/59 | 23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery | 23d. LOCATION (City, town, or county) St. Louis County, Mo. | |
| 24. FUNERAL DIRECTOR ADDRESS Charles J. Gates, 4107 Finney | | 25. DATE RECD. BY LOCAL REG. OCT 14 '59 | 26. REGISTRAR'S SIGNATURE Roan Smith, M.D. | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

m d b

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

Guyton Swan

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

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.