URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 1 9 1959

59-041712

STATE FILE NUMBER

ENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210331

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St Louis

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer Phillips Hosp

Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY

c. CITY OR TOWN: St Louis

Inside Limits: Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location): 4365 Garfield Ave.

Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)
First: Zella
Middle:
Last: Crawford

4. DATE OF DEATH: Month: Nov. Day: 6 Year: 59

5. SEX: Female

6. COLOR OR RACE: Negro

7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☒

8. DATE OF BIRTH: 19 Dec 1915

9. AGE (last birthday): 43

IF UNDER 1 YEAR: Months: Days:

IF UNDER 24 HR: 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: Housewife

11. BIRTHPLACE (City and state or country): Memphis Tenn

12. CITIZEN OF WHAT COUNTRY: U S

13a. FATHER'S NAME: Benjamin H Simms

13b. MOTHER'S MAIDEN NAME: Alice

14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Julia Crawford Jordan

Address: 4365 Garfield

DOCUMENT

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): cerebral hemorrhage — Cerebral hemorrhage

DUE TO (b): hypertension — Hypertension

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (c): 331x

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. ☐ Yes ☑ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 Oct 18 58 to Nov. 6 59 and last saw her alive on Oct. 12 - 59

Death occurred at 7:15 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

BY AFFIDAVIT OF

22a. SIGNATURE: Chas. Weekes (Degree or title) M.D.

Charles Weekes MD

22b. ADDRESS: 4069 Easton Ave

22c. DATE SIGNED: 11-9-59

23a. BURIAL, CREMATION, REMOVAL (Specify): removal

23b. DATE: 11 Nov 59

23c. NAME OF CEMETERY OR CREMATORY: Washington Park

23d. LOCATION (City, town, or county) (State): St Louis Co Mo

24. FUNERAL DIRECTOR: Reliable Funeral Svs

ADDRESS: 1389 N Union

25. DATE RECD. BY LOCAL REG.: NOV 10 1959

26. REGISTRAR'S SIGNATURE: Earl Smith. M.D.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Paul V. Freeman

Signature of Student Embalmer

Licensed Embalmer No. 4686

P. O. Address 1389 Unio

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.