

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041814

FILED VS NOV 30 1959

210602

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar _____

| | | | | | | | | |
|---|--|---|-----------------------------------|--|--|--|----------------------------------|-------|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN | | Length of stay in 1b | | c. CITY OR TOWN | | Inside Limits | | |
| St. Louis | | 6 days | | Eolia | | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | | | d. STREET ADDRESS (If outside, give location) | | Reside on Farm | | |
| Missouri Pacific Hosp. | | | | Route #2 | | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | | | 4. DATE OF DEATH | | | Month Day Year | | |
| First Middle Last | | | November 15, 1959 | | | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH | | |
| Female | | White | | | | 5-29-05 | | |
| 9. AGE (last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HR | | | | |
| 54 | | Months Days Hours Min. | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) | | 12. CITIZEN OF WHAT COUNTRY | |
| Housewife | | | Home | | Beebe, Arkansas | | U.S.A. | |
| 13a. FATHER'S NAME | | | 13b. MOTHER'S MAIDEN NAME | | | 14. NAME OF HUSBAND OR WIFE | | |
| Teen Eckels | | | Unknown | | | Henry A. Ferguson | | |
| 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 | | | |
| no | | | none | | Henry A. Ferguson, Eolia, Mo. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH ONLY CAUSED BY: | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) | | | | | | | 3-4 days | |
| Cocheria, Meningo bronchopneumonia | | | | | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | unknown | |
| DUE TO (b) | | | | | | | | |
| Generalized osseous metastases | | | | | | | | |
| DUE TO (c) | | | | | | | | |
| Cause unknown | | | | | | | | |
| 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 | | |
| 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 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 Nov. 10-1959 to Nov. 15-1959 and last seen ^{her} him alive on Nov. 15-1959 | | | | | | | | |
| Death occurred at 11:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) | | | | 22b. ADDRESS | | | 22c. DATE SIGNED | |
| Barth Passanante, M.D. | | | | 1755 So. Grand, St Louis Mo | | | 11/17/59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | | |
| Removal | | 11-18-1959 | | Laurel Hill Gardens | | Pagedale, Missouri | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. | | 26. REGISTRAR'S SIGNATURE | | |
| Baumann Bros. Inc. Overland, Mo. | | 2504 Woodson Rd. | | NOV 17 1959 | | Karl Smith, M.D. | | |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

m 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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed David C. Gibson

Licensed Embalmer No. 3454

P. O. Address Parlana

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.