URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 1 9 1959

59–041996

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's 210123

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 G. Phillips
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 2145 Hickory
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Armster Middle: Last: Holloway
4. DATE OF DEATH Month: 11 Day: 1 Year: 59
5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: Unknown
9. AGE (last birthday): 74
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): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): Monroe, Miss
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Berry Holloway
13b. MOTHER'S MAIDEN NAME: Opyelia Redmond
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: Rev. R. Willis
Address: 2918 Caroline

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): Adenocarcinoma of Prostate with Metastatic
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (a): Bone Lesions on Spine, Pelvis and Left Rib Cage
DUE TO (c): 177K
INTERVAL BETWEEN ONSET AND DEATH: Undet.
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 10-12-59, to 11-1-59 and last saw him alive on 11-1-59
Death occurred at 5:45 P m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: Edward B. Weinrich (Degree or title)
22b. ADDRESS: 2601 N. Whittier St.
22c. DATE SIGNED: 11-3-59
23a. BURIAL, CREMATION, REMOVAL (Specify): Rem oval
23b. DATE: 11-8-59
23c. NAME OF CEMETERY OR CREMATORY: Father Dickson
23d. LOCATION (City, town, or county) (State): Kirkwood, Mo.
24. FUNERAL DIRECTOR: A.L. Beal Und.Co.
ADDRESS: 4303 Delmar
25. DATE RECD. BY LOCAL REG.: NOV 4 1959
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

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 C. D. Richardson

Signature of Student Embalmer

Licensed Embalmer No. 2928

P. O. Address C. C.

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.