URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 19 1959

59–042005
STATE FILE NUMBER

MENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210110

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOIS
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: Mo
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4137 Fairfax
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Mack Middle: Last: House
4. DATE OF DEATH: Month: Nov Day: 2 Year: 1959
5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 6/15/1898
9. AGE (last birthday): 61
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): Labor
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Ky
12. CITIZEN OF WHAT COUNTRY: U.S.A
13a. FATHER'S NAME: Sam House
13b. MOTHER'S MAIDEN NAME: Annie Brodin
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: Mary Slater Address: 4137 Fairfax

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): Hypertensive Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10-15-59 to 11-2-59
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 443x

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 6-5-67 to 11-2-59 and last saw ~~her~~ him alive on 10-15-59
Death occurred at 12:15 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Robert M. Scott, M.D.
22b. ADDRESS: 3007 Easton Ave.
22c. DATE SIGNED: 11-3-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Nov 7, 1959
23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cem
23d. LOCATION (City, town, or county) (State): St Louis County Mo

24. FUNERAL DIRECTOR: F. A. Gillen ADDRESS: 4214 Delmar
25. DATE RECD. BY LOCAL REG.: NOV 4 1959
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. MGB

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

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_____ Signed F. A. Green

Signature of Student Embalmer

Licensed Embalmer No. 2963

P. O. Address 4214 Selma

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