URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 2 0 1959

59-042164
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210390

MENDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis Mo
Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 2429 Biddle Apt 1013
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): 2429 Biddle Apt 1013
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Rhonda Middle Lomax Last
4. DATE OF DEATH: Month 10 Day 17 Year 59
5. SEX: Fem
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH
9. AGE (last birthday) IF UNDER 1 YEAR: Months 2 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): Mo
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Unk
13b. MOTHER'S MAIDEN NAME: Unk
14. NAME OF HUSBAND OR WIFE: Unk
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unk
16. SOCIAL SECURITY NO.: Unk
17. INFORMANT: Vo. Jay Ins Co Address 1300 Clark

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Suffocation, Suffered
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): When found Under Spread
DUE TO (c): on Bed in house on or about 10-17-59
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): Accident 924.018

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: 10 17 59 213 Suffocation
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.): Home
20f. CITY, TOWN, OR LOCATION: St Louis COUNTY STATE Mo

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Paul J Simon Deputy Coroner
22b. ADDRESS: 1300 Clark
22c. DATE SIGNED: 10/26/59

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE: 11-30-59
23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR ADDRESS: Rowland Aker Mortuary Service, 4104 Manchester Ave., St. Louis 10, Mo.
25. DATE RECD. BY LOCAL REG.: NOV 12 1959
26. REGISTRAR'S SIGNATURE: Carl Smith, M.D. M.J.B.

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

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 me

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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.