URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59-042215

FILED VS NOV 30 1959

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210288 STATE FILE NUMBER

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 [X] 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 [X] No [ ]
d. STREET ADDRESS (If outside, give location): 1340 Bayard
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Abraham; Middle: ; Last: Maples
4. DATE OF DEATH: Month: 11; Day: 6; Year: 59
5. SEX: Male
6. COLOR OR RACE: Negro
7. Married [X] Never Married [ ] Widowed [ ] Divorced [ ]
8. DATE OF BIRTH: 3-14-1881
9. AGE (last birthday): 78
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): Custodian
10b. KIND OF BUSINESS OR INDUSTRY: City Hall
11. BIRTHPLACE (City and state or country): Athens, Alabama
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Abe Maples
13b. MOTHER'S MAIDEN NAME: Martha (Unknown)
14. NAME OF HUSBAND OR WIFE: Lizzie Maples
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.: Unknown
17. INFORMANT: Lizzie Maples, Address: 1340 Bayard

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 Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 332x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Left Hemiplegia, Chronic Glomerulonephritis, Uremia
PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [ ] No [ ] Unknown
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
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 11-3-59, to 11-6-59 and last saw her/him alive on 11-6-59
Death occurred at 8:55 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): Sidney C. Frazier
22b. ADDRESS: 2601 N. Whittier St.
22c. DATE SIGNED: 11-9-59
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 11-10-59
23c. NAME OF CEMETERY OR CREMATORY: Washington Park
23d. LOCATION (City, town, or county) (State): St. Louis County, Mo.
24. FUNERAL DIRECTOR: W.D. Richardson ADDRESS: 2625 Glasgow
25. DATE RECD. BY LOCAL REG.: NOV 9 1959
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. 4.D.

(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 m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Andrew Richard

Signature of Student Embalmer

Licensed Embalmer No. 4858

P. O. Address 2625 Glas

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.