

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS NOV 19 1959

59-042328

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **210235**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1 yr. 5 weeks		c. CITY TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3642 Botanical Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Charles Middle Organ Last Organ			4. DATE OF DEATH Month 11 Day 5 Year 59		
5. SEX male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH MAR. 12 1884	9. AGE (last birthday) 75	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHIPPING CLERK		10b. KIND OF BUSINESS OR INDUSTRY FAIRBANKS MORRIS		11. BIRTHPLACE (City and state or country) Ill.	
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 NETTIE ORGAN (DEC'D)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. _____	
17. INFORMANT JUNE CARLISLE 3642 BOTANICAL		Address			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Interstitial Pneumonia.		INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		492x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Arteriosclerosis - 1 yr.		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. 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 **9-15-58** to **11-5-59** and last saw ^{her}him alive on **11-5-59**
 Death occurred at **11:00 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John W. Beekham, M.D.		22b. ADDRESS 5800 Arsenal		22c. DATE SIGNED 11/6/59
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE NOV. 7 1959	23c. NAME OF CEMETERY OR CREMATORY Mo. CREMATORY		23d. LOCATION (City, town, or county) (State) ST. LOUIS Mo.
24. FUNERAL DIRECTOR Thomas Lutz 2906 Lewis		25. DATE RECD. BY LOCAL REG. NOV 7 1959		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.

L.P.

DOCUMENT

MEDICAL CERTIFICATION

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
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James C. Hill

Licensed Embalmer No. 4347

P. O. Address 2906 Sta

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