URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 2 0 1959

59–042683

STATE FILE NUMBER

ENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's 210279

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Saint 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: Saint Louis — Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location): 2738 Gamble Street — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Golden — Middle: NMN — Last: Washington

4. DATE OF DEATH: Month 11 — Day 5 — Year 59

5. SEX: Male

6. COLOR OR RACE: Colored

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 8-22-1900

9. AGE (last birthday): 59 — IF UNDER 1 YEAR: Months 2, Days 13 — IF UNDER 24 HR: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (City and state or country): Mississippi

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: George Washington

13b. MOTHER'S MAIDEN NAME: Tena ?

14. NAME OF HUSBAND OR WIFE: Vickie Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWI

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: Vickie Washington — Address: 2738 Gamble St.

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): Cardiac Arrest

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

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): Suffered following operation (exploratory) at

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: 11 5 59 — H. Phillips Hospital on Nov 5, 1959

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.): 113 Hosp

20f. CITY, TOWN, OR LOCATION: St Louis — COUNTY — STATE: Mo

21. I attended the deceased from _____ and last saw her/him alive on _____

Death occurred at 925 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Patrick C. Taylor (Degree or title) Coroner — 22b. ADDRESS: 1300 Clark — 22c. DATE SIGNED: 11.9.59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal — 23b. DATE: 11-12-59 — 23c. NAME OF CEMETERY OR CREMATORY: National Cemmetery — 23d. LOCATION (City, town, or county) (State): Jefferson Bks. Missouri

24. FUNERAL DIRECTOR: Ellis Funeral Home — ADDRESS: 2820 Stoddard St.

25. DATE RECD. BY LOCAL REG.: NOV 9 1959

26. REGISTRAR'S SIGNATURE: Earl Smith M.D. MJB

(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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Fulton E. Cul

Signature of Student Embalmer

Licensed Embalmer No. 419

P. O. Address St Rai

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