

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 45 2 0 1

FILED VS. JAN - 4 1960

211605

STATE FILE NUMBER

INDEXED

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS Mo</i>		c. CITY OR TOWN <i>ST. LOUIS</i>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>ST. LOUIS CITY HOSPITAL</i>		d. STREET ADDRESS (If outside, give location) <i>5800 ARSENAL</i>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <i>IDA CHILDRESS ASKEW</i>			4. DATE OF DEATH Month Day Year <i>DEC. 17 1959</i>				
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>FEB 1 1880</i>	9. AGE (last birthday) <i>79</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>WIDOW</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (City and state or country) <i>Tennessee</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	

13a. FATHER'S NAME <i>COLUMBUS TIBBS</i>		13b. MOTHER'S MAIDEN NAME <i>LUCINDA HAYWARD</i>		14. NAME OF HUSBAND OR WIFE <i>UNKNOWN</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT Address <i>THOMAS CHILDRESS CHICAGO ILL</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fractured Left Hip</i> DUE TO (b) <i>Generalized Arteriosclerosis.</i> DUE TO (c) <i>902.745</i>		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)		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

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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, item 18.) <i>Suffered in fall from chair in Dr. #23 St. Louis Avenue</i>
20c. TIME OF INJURY Hour a.m. p.m. <i>11:25 p.m.</i>	Month, Day, Year <i>Hospital on Nov 25, 1959.</i>	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>131 Hop</i>	20f. CITY, TOWN, OR LOCATION <i>St Louis Mo</i>	COUNTY	STATE
21. I attended the deceased from <i>320 P</i> to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <i>Joseph M. Duncan</i>	22b. ADDRESS <i>1300 elder</i>	22c. DATE SIGNED <i>12/15/59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>DEC. 15 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>BELLEFONTAINE CEM.</i>	23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS Mo</i>

24. FUNERAL DIRECTOR <i>Thomas Kuter 2906 Gravois</i>	25. DATE RECD. BY LOCAL REG. <i>DEC 15 1959</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith. M.D.</i>
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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 me

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

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