

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 45362

FILED VS DEC 23 1959

211601

STATE FILE NUMBER

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) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		Length of stay in 1b <b>7 Days</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1522 N. 15th St.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>.</b> Last <b>DAVIS</b>			4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>12</b> , Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4-28-1896</b>	9. AGE (last birthday) <b>63</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unemployed</b>	11. BIRTHPLACE (City and state or country) <b>UNKNOWN</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>James Davis</b>		13b. MOTHER'S MAIDEN NAME <b>Fannie LAST NAME UNKNOWN</b>		14. NAME OF HUSBAND OR WIFE <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW-1</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT Address <b>Pacific Mo</b> <b>M.V. BRADSHAW Rt 2 Box 174</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Pulmonary Infarction</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>auricular fibrillation &amp; <del>stroke</del></b>	<b>Unknown</b>
	DUE TO (c) <b>Arteriosclerotic heart disease</b>	<b>15 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>420.0</b>		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 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 **4 Dec, 1959** to **12 Dec, 1959** and last saw her/him alive on **12 Dec, 1959**  
Death occurred at **04:00 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Nicholas Owsy - M.D.</b> (Degree or title)	22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>	22c. DATE SIGNED <b>12 Dec 59</b>
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23a. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Dec. 15, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Trinity Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>2000 Lemay Ferry Rd. Lemay, Mo.</b>
24. FUNERAL DIRECTOR <b>C. Hoffmeister Mortuaries</b> ADDRESS <b>7814 S. Broadway</b>		25. DATE RECD. BY LOCAL REG. <b>DEC 15 1959</b>	26. REGISTRAR'S SIGNATURE <b>Roal Smith, M.D.</b> <i>mjc</i>

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 Bill C. Branson

Licensed Embalmer No. 4764

P. O. Address St Louis, Mo

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