

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS DEC 21 1959**

**211369** '59 0 45 48  
 STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's \_\_\_\_\_

|  |  |   |   |   |  |  |   |   |  |   |  |                |  |
|--|--|---|---|---|--|--|---|---|--|---|--|----------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY                                 |  |  |   |   |  |   |  |                |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>ST. LOUIS, MO.</b>   |  | Length of stay in 1b  |   | c. CITY OR TOWN <b>St. Louis</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |   |  |   |  |                |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1</b>  |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)<br><b>178 Marion Ave</b> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   |  |   |  |                |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>ESTER</b> Middle <b>Margaret</b> Last <b>GREEN</b>  |  |   |   | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>6</b> Year <b>1959</b>   |  |  |   |   |  |   |  |                |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>Negro</b>  |   | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>7-29-1896</b>   |   | 9. AGE (last birthday) <b>63</b>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | IF UNDER 24 HR |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis, Mo</b>                   |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A</b>                                       |  |   |  |                |  |
| 13a. FATHER'S NAME<br><b>James Silas Hillard</b>   |  |   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Anna Tamer Ellis</b>  |  |  |   | 14. NAME OF HUSBAND OR WIFE<br><b>Dead</b>  |  |   |  |                |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |   |   | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br><b>Isadora Jackson 5320 Bulwer Ave</b>                              |   |   |  | Address   |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute pyelonephritis c</b><br>septicemia due to Stone<br>obstructing Rt pelvis and ureter.                                      |  |   |   |   |  |  |   |   |  | 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)<br><b>602x</b>   |  |   |   |   |  |  |   |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  |                |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.<br>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 <b>December 3, 1959</b> to <b>December 6, 1959</b> and last saw her/him alive on <b>December 6, 1959</b><br>Death occurred at <b>4:10 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |   |   |  |  |   |   |  |   |  |                |  |
| 22a. SIGNATURE<br><i>John M. Kearney MD</i> (Degree or title)  |  |   |   | 22b. ADDRESS<br><b>1515 LAFAYETTE AVE.</b>  |  |  |   | 22c. DATE SIGNED<br><b>12-6-59</b>  |  |   |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |  | 23b. DATE<br><b>12/12/59</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenwood Cemetery</b>   |  |  |   | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis County Missouri</b> |  |   |  |                |  |
| 24. FUNERAL DIRECTOR<br><b>C.W. Roberts Und.Co 1416 N. Taylor Ave</b> ADDRESS  |  |   |   | 25. DATE RECD. BY LOCAL REG.<br><b>DEC 8 1959</b>   |  | 26. REGISTRAR'S SIGNATURE<br><i>Loan Smith, M.D.</i><br><i>m &amp; B.</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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed James A Carter  
Licensed Embalmer No. 4681  
P. O. Address Sp. Joe M

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.