

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 6 7 0

FILED VS. JAN - 8 1960

211931

STATE FILE NUMBER

ENDED

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

1. PLACE OF DEATH 1331 a. COUNTY 131a Biddle		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		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1331 Biddle St.		d. STREET ADDRESS (If outside, give location) 1331 Biddle	

3. NAME OF DECEASED (Type or print) First Middle Last Effie Rogers Lewellen			4. DATE OF DEATH Month 12 Day 22 Year 1959	
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5. SEX Female	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-12-1906	9. AGE (last birthday) 53	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Jackson Tenn	12. CITIZEN OF WHAT COUNTRY U.S.A
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13a. FATHER'S NAME John Taylor	13b. MOTHER'S MAIDEN NAME Lucy Person	14. NAME OF HUSBAND OR WIFE Williams Lewellen
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT William Lewellen Address 1331a Biddle
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis DUE TO (b) Hypertension DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH Lyr 2 wks 5 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) none		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.)
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20c. TIME OF INJURY Hour 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
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21. I attended the deceased from Jan 6 1959, to Dec 22, 1959 and last saw her alive on Dec 22, 1959 Death occurred at 6:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) Thos J. Smith Jr M.D.	22b. ADDRESS 1418 Orenkbin, St Louis, Mo	22c. DATE SIGNED 12-24-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-28-59	23c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.	23d. LOCATION (City, town, or county) Berkley Mo.
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24. FUNERAL DIRECTOR ADDRESS Hill & Radford 1713 N. Grand.	25. DATE RECD. BY LOCAL REG. DEC 24 1959	26. REGISTRAR'S SIGNATURE Loan Smith, M.D. mjc
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(Licensed Embalmer's Statement on Reverse Side)

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 Larry E. Bennett

Licensed Embalmer No. 4523

P. O. Address 4251 WASHINGTON

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.