

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 6 7 9

FILED VS DEC 21 1959

211351

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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 3 days	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5979 Arsenal Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Ottis Middle Logan Last Livesay			4. DATE OF DEATH Month December Day 6 Year 1959			
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5. SEX Male	6. COLOR OR RACE Caucasian	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/6/1883	9. AGE (last birthday) 76	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) Retired Treasure	10b. KIND OF BUSINESS OR INDUSTRY Anheuser-Busch	11. BIRTHPLACE (City and state or country) Centrallia, Illinois	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Jackson Livesay	13b. MOTHER'S MAIDEN NAME Emmer Ingram	14. NAME OF HUSBAND OR WIFE Jeannette Livesay
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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) No	16. SOCIAL SECURITY NO. 492-07-9705	17. INFORMANT Address St. Louis Mrs. Jeannette Livesay, 5979 Arsenal St.
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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) PULMONARY EDEMA ACUTE 10 MIN?		INTERVAL BETWEEN ONSET AND DEATH 2 YEARS
DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE		2 YEARS +
OR (c) ARTEROSCLEROSIS		443 + 2 YEARS +

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) FRACTURE SECOND CERVICAL VERTEBRA AND CONTUSIONS OF CERVICAL MATTER SCLEROSIS, MARKED	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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) BECAME DIZZY AND FELL IN DINING ROOM OF HOME - STRUCK HEAD AGAINST TABLE
20c. TIME OF INJURY 6:15 p.m. DEC. 2 1959		

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.) IN HOME	20f. CITY, TOWN, OR LOCATION ST. LOUIS COUNTY MISSOURI STATE
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21. I attended the deceased from **JULY 11 1957** to **DECEMBER 6, 1959** and last saw him alive on **DECEMBER 4, 1959**
Death occurred at **12:30 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Reginald V. Fenschel, M.D.	22b. ADDRESS 4401 Hampton Ave	22c. DATE SIGNED 12/7/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 12/9/1959	23c. NAME OF CEMETERY OR CREMATORY Vallhalla Crematory	23d. LOCATION (City, town, or county) St. Louis 7600 St. Charles Rock Rd.
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24. FUNERAL DIRECTOR Hoffmeister Colonial Mortuary 646 Chippewa St., St. Louis, Mo.	25. DATE RECD. BY LOCAL REG. DEC 7 1959	26. REGISTRAR'S SIGNATURE Leard Smith, M.D.
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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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Bill C. Brunson

Licensed Embalmer No. 476

P. O. Address St Louis

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.