

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 7 8 3

FILED VS JAN 11 1960

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar **211849**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 3 1/2 wks.	c. CITY OR TOWN Florissant Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2625 Steeplechase La. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) MR. ROBERT MILLER NORTH			4. DATE OF DEATH Month December Day 20 , Year 1959
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/25/1919
9. AGE (last birthday) 40		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Selb Mfg. Co.	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Joseph T. North	13b. MOTHER'S MAIDEN NAME Irene Offill
14. NAME OF HUSBAND OR WIFE Elizabeth Ley North		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW2	16. SOCIAL SECURITY NO. 490-03-5416
17. INFORMANT Mrs. R.M. North		Address 2625 Steeplechase I	

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) ESOPHAGEAL VARICES		4 YEARS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) CIRRHOSIS OF LIVER	4 YEARS
	DUE TO (c) _____	

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	
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19. WAS AUTOPSY PERFORMED? 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 Hour _____ Month, Day, Year _____ s.m. _____ p.m. _____	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 **JUNE 1959** to **DEC. 20, 1959** and last saw her/him alive on **DEC. 20, 1959**
Death occurred at **5:30 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Lawrence W. O'Neal</i> (Destroy or title) M. D.	22b. ADDRESS 100 North Euclid	22c. DATE SIGNED 12/21/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/22/1959	23c. NAME OF CEMETERY OR CREMATORY Jefferson Barracks Natl.	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
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24. FUNERAL DIRECTOR Alexander & Sons	ADDRESS 6175 Delmar Blvd.	25. DATE RECD. BY LOCAL REG. DEC 21 1959	26. REGISTRAR'S SIGNATURE <i>Neal Smith</i> 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 jos. E. McCulloch

Licensed Embalmer No. 246

P. O. Address 6170 R

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.