

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 8 7 3

FILED VS. JAN - 4 1960

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's **211259**

INDEXED

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, MO.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1		d. STREET ADDRESS (If outside, give location) 2312 Menard	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) CORA First Dalton Middle RIOLA Last			4. DATE OF DEATH DEC. Month 2 Day 1959 Year		
---	--	--	--	--	--

5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/23/78	9. AGE (last birthday) 8 1	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
-------------------------	----------------------------------	---	-------------------------------------	--------------------------------------	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	--	---	--

13a. FATHER'S NAME John Womack	13b. MOTHER'S MAIDEN NAME Sarah Caruthers	14. NAME OF HUSBAND OR WIFE None
--	---	--

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. Unknown	17. INFORMANT Address Mary Rariden, Webb City, Missouri
---	---	---

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) Congestive Heart failure		
DUE TO (b) Arteriosclerotic Heart Disease		
DUE TO (c) 420.0		
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 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.)
---	---	--

20c. TIME OF INJURY Hour _____ a.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 NOV. 28, 1959 to DEC. 2, 1959 and last saw her/him alive on DEC. 2, 1959	
Death occurred at 7:43 pm on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) W. Leightner M.D.	22b. ADDRESS 1515 LAFAYETTE AVE.	22c. DATE SIGNED 12/2/59
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/5/59	23c. NAME OF CEMETERY OR CREMATORY St. Matthews	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
--	-----------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS McLaughlin, 2301 Lafayette (4)	25. DATE RECD. BY LOCAL REG. DEC 4 1959	26. REGISTRAR'S SIGNATURE Karl Smith, M.D.
---	---	--

(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 H. G. Farris

Licensed Embalmer No. 338

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.