

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 9 3 5

FILED VS. DEC 23 1959

211311

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY		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 DOA City Hosp. II		d. STREET ADDRESS (If outside, give location) 2819 Cass Ave.,	

3. NAME OF DECEASED (Type or print) First Andrea Middle Scott Last			4. DATE OF DEATH Month Dec. Day 3 Year 1959		
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5. SEX Female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH "3 Jul. 59	9. AGE (last birthday) 5 Months Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXX	10b. KIND OF BUSINESS OR INDUSTRY XXXX	11. BIRTHPLACE (City and state or country) St. Louis Mo.	12. CITIZEN OF WHAT COUNTRY U.S.
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13a. FATHER'S NAME Louis Winston	13b. MOTHER'S MAIDEN NAME Wanda Scott	14. NAME OF HUSBAND OR WIFE XXXX
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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. no	17. INFORMANT Address Sarah Cross 2819 Cass Ave.,
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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) Bilateral Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		491x

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 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.)
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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
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at _____ **8:50 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Patrick Taylor, Coroner	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 12.7.59
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23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 9 Dec. 1959	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Mo.
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24. FUNERAL DIRECTOR ADDRESS Reliable Funeral Sys. 1389N. Union	25. DATE RECD. BY LOCAL REG. DEC 7 1959	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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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 Paul V. Green

Licensed Embalmer No. 468

P. O. Address 1389 N 20

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.