

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003511

FILED VS FEB 1 0 1960

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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 <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N GRAND ST LOUIS MO</b>	Length of stay in 1b <b>13 DAYS</b>	c. CITY OR TOWN <b>ST LOUIS</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETS ADMIN HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>2901 DELMAR</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>COLUMBUS</b>	First	Middle	Last	4. DATE OF DEATH Month <b>JANUARY</b> Day <b>25</b> Year <b>1960</b>
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/21/97</b>	9. AGE (last birthday) <b>62</b>	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) <b>PORTER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Chronic Hosp</b>	11. BIRTHPLACE (City and state or country) <b>LAKE PROVIDENCE, LA</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>JOHNEY HARRIS</b>	13b. MOTHER'S MAIDEN NAME <b>HATTIE NELSON</b>	14. NAME OF HUSBAND OR WIFE -----
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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) <b>YES WW I</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>6650 MAFFITT COZY MARKS SR. ST LOUIS MO.</b>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<b>PNEUMONIA - LOBAR</b>	<b>48 HOURS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>- 490X</b>	-
	DUE TO (c) <b>-</b>	-

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 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 _____ a.m. _____ p.m.	Month, Day, Year
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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. **VA** attended the deceased from **1/12/60** to **1/25/60** and last saw him alive on **1/25/60**  
Death occurred at **8:50 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Caroline Newton</i> <b>CAROLINE NEWTON, M.D.</b>	22b. ADDRESS <b>VAH, ST LOUIS, MO.</b>	22c. DATE SIGNED <b>1/27/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>1/30/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREENWOOD CEMETERY</b>	23d. LOCATION (City, town, or county) <b>St. Louis County, Mo.</b>
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24. FUNERAL DIRECTOR <b>Charles J. Gates</b>	ADDRESS <b>4107 Finney Ave.</b>	25. DATE RECD. BY LOCAL REG. <b>JAN 29 1960</b>	26. REGISTRAR'S SIGNATURE <i>Earl Smith</i> <b>M.D.</b>
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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

*Lawrence Woodson*  
4341

Licensed Embalmer No. 4580

P. O. Address 4107 Finney A

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.