

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003535
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STATE FILE NUMBER

Registration District No. 113 Primary Registration District No. _____ Registrar's No. 2 113

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Homer G. Phillips</u>		d. STREET ADDRESS (If outside, give location) <u>2735 Lucas</u>	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle _____ Last <u>Henderson</u>		4. DATE OF DEATH Month <u>1</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY <u>Pension</u>	11. BIRTHPLACE (City and state or country) <u>Batesville Miss</u>
13a. FATHER'S NAME <u>Elliott Black</u>		13b. MOTHER'S MAIDEN NAME <u>Susie Black</u>	14. NAME OF HUSBAND OR WIFE _____
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-10</u>	17. INFORMANT Address <u>Lucile Barrett-2735 Lucas</u>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2nd and 3rd degree burns of 30% of body.</u>		INTERVAL BETWEEN ONSET AND DEATH _____	
DUE TO (b) _____		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	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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) <u>Shuffled while climbing of deceased was injured</u>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year <u>11 29 59</u>	20d. PLACE OF INJURY (a, or, in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis Mo</u>	COUNTY _____ STATE _____
21. I attended the deceased from _____ and last saw her/him alive on _____		Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Edward D. Smith</u>		22b. ADDRESS <u>1200 Clark</u>	22c. DATE SIGNED <u>1-5-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Shipped</u>	23b. DATE <u>1-7-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Marks Colored Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Clarksdale Miss</u>
24. FUNERAL DIRECTOR ADDRESS <u>Hill & Radford, 1713 N. Grand</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 5 1960</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

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 Leroy H. Gammeter

Licensed Embalmer No. 4523

P. O. Address 4257 Wash

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.