

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003703

FILED VS JAN 29 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 503** STATE FILE NUMBER

INDEXED

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		Length of stay in 1b LIFE	c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION HOMER PHILLIPS			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3964 KENNERLY	
3. NAME OF DECEASED (Type or print) First Middle Last MICHAEL LEE			4. DATE OF DEATH Month Day Year 1 13 60		
5. SEX MALE	6. COLOR OR RACE COLORED	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-16-59	9. AGE (last birthday)	IF UNDER 1 YEAR Months Days Hours Min. 1 27
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME EDGAR ANDERSON		13b. MOTHER'S MAIDEN NAME SHIRLEY LEE		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) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address SHIRLEY LEE 3964 KENNERLY	

DOCUMENT

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Atelectasis**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) **Congestion of Lung**

DUE TO (c) **522x**

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.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

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 **4:30 P.** to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

BY AFFIDAVIT OF

22a. SIGNATURE (Degree, title)
Paul Simon Deputy Coroner

22b. ADDRESS
1300 Clark

22c. DATE SIGNED
1/15/60

23a. BURIAL, CREMATION, REMOVAL (Specify)
REMOVAL

23b. DATE
1-16-60

23c. NAME OF CEMETERY OR CREMATORY
OAKDALE

23d. LOCATION (City, town, or county) (State)
ST. LOUIS CO. MO.

24. FUNERAL DIRECTOR ADDRESS
PETTIS FUNERAL HOME 4181 WASHINGTON

25. DATE RECD. BY LOCAL REG.
JAN 15 1960

26. REGISTRAR'S SIGNATURE
Carl Smith, M.D.

212B

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Eather S. Harris

Licensed Embalmer No. 445-8

P. O. Address 4181 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.