

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004447

FILED JVS FEB 1 1960 3/7

Registration District No. _____ Primary Registration District No. 547 Registrar's No. 131 STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights</u>		Length of stay in 1b <u>60 yrs.</u>	c. CITY OR TOWN <u>Richmond Heights</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Hospital (DOA)</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>7200 Delta Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE MORTON CUMMINGS</u>			4. DATE OF DEATH Month Day Year <u>January 13, 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3/20/1895</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SW Bell Teleph. Co.</u>		11. BIRTHPLACE (City and state or country) <u>Sedalia, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>George B. Cummings</u>		13b. MOTHER'S MAIDEN NAME <u>Claudine Morton</u>		14. NAME OF HUSBAND OR WIFE <u>Nadine L. Cummings</u>		

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>488-03-6215</u>	17. INFORMANT Address <u>N.L. Cummings 7200 Delta Ave.</u>
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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) <u>Acute myocardial infarction acute</u>		<u>several days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>arteriosclerotic heart dis</u>	
	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 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. Month, Day, Year		

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 <u>2/12/1958</u> to <u>1/13/1960</u> and last saw him alive on <u>1/5/60</u> Death occurred at <u>1:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <u>Thomas P. Tucker M.D.</u>	22b. ADDRESS <u>4660 Maryland</u>	22c. DATE SIGNED <u>1/13/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1/15/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Pickers Cemetery</u>
24. FUNERAL DIRECTOR ADDRESS <u>Alexander & Sons 6175 Delmar Blvd.</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>

25. DATE RECD. BY LOCAL REG. <u>1-14-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. M... M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. T.W. Parker
4660 Maryland

FO 1-6074

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 jos. e. mc cullott

Licensed Embalmer No. 2460

P. O. Address 6175

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.