URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-008134

STATE FILE NUMBER

FILED VS MAR 7 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 2118

NDED

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS — Length of stay in 1b

c. CITY OR TOWN ST. LOUIS — Inside Limits Yes ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION HOMER Phillips HOSP. — Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 2708 HOWARD ST. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First MALINDA Middle DOLHART Last

4. DATE OF DEATH Month 2 Day 22 Year 60

5. SEX FEMALE

6. COLOR OR RACE Colored

7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐

8. DATE OF BIRTH OCT. 1-1897

9. AGE (last birthday) 62 YRS — IF UNDER 1 YEAR Months 4 Days 21 — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NIL

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) CARUTHERSVILLE, MO.

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME ALEX DURHAM

13b. MOTHER'S MAIDEN NAME LENA STOKES

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Irene Anderson Address 2708 Howard

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) 420.1

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Coronary Occlusion

DUE TO (c) Coronary Sclerosis

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 1:1, to _____ and last saw her/him alive on _____

Death occurred at 1:45A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph M. Quinn Deputy Prem

22b. ADDRESS 1300 Clark

22c. DATE SIGNED 2-23-60

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

23b. DATE 2-29-60

23c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK CEM

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

24. FUNERAL DIRECTOR A.F. WALTON ADDRESS 2707 STODDARD

25. DATE RECD. BY LOCAL REG. FEB 23 1960

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

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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_____ Signed W. Claude Go

Signature of Student Embalmer

Licensed Embalmer No. 348

P. O. Address 11237

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