

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-008352

FILED VS FEB 23 1960

2 1305

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN St. Louis, Missouri	
c. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 5547 Etzel Avenue	

3. NAME OF DECEASED (Type or print) First JAMES Middle (JIM) Last HILL			4. DATE OF DEATH Month FEBRUARY Day 1 Year 1960		
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/2/1903	9. AGE (last birthday) 56	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Barnes Hospital		11. BIRTHPLACE (City and state or country) Wilks Co, Georgia	
13a. FATHER'S NAME Jim (James) Hill		13b. MOTHER'S MAIDEN NAME Jane Julia Sail		14. NAME OF HUSBAND OR WIFE Deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO.		17. INFORMANT Address Annie Hocomb 3849 Evans Avenue	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA, PRIMARY SITE UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 199.2		
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 **JAN. 6, 1960** to **FEB. 1, 1960** and last saw her/him alive on **FEB. 1, 1960**
 Death occurred at **9:45 P.M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C. B. Koonce, M.D.		22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 2/2/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2/5/60	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Missouri	

24. FUNERAL DIRECTOR C. B. Koonce	ADDRESS 1221 North Grand	25. DATE RECD. BY LOCAL REG. FEB 4 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

mdb

STATEMENT BY LICENSED EMBALMER

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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 Melvin Blackman

Licensed Embalmer No. 3967

P. O. Address 1721 N 2

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.