URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS MAR 8 1960

-60-008544
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 2233

NDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 8mo.&20days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Chronic Hospital
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4130 Fairfax
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Jimmie; Middle: ; Last: Lucas
4. DATE OF DEATH: Month: 2; Day: 24; Year: 60
5. SEX: Female
6. COLOR OR RACE: Colored
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 4/5/85
9. AGE (last birthday): 74
IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HR: Hours: ; Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: Pvt Family
11. BIRTHPLACE (City and state or country): Mississippi
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Louis Ransom
13b. MOTHER'S MAIDEN NAME: Mary Elizabeth Nelson
14. NAME OF HUSBAND OR WIFE: None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: UNK
17. INFORMANT: Beekie Williams Address: 4130 Fairfax

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) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 9mo.
420.0
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) Generalized Arteriosclerosis — 9mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Chronic Brain Syndrome — 9mo.
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. Month, Day, Year: 10:45 P.M. 2/24/60
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.): ~~Chronic Hospital~~
20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from May 20, 1959, to 2/24/60 and last saw her/him alive on 2/24/60
Death occurred at 10:45 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): John W. Beckham, M.D.
22b. ADDRESS: 5800 Arsenal
22c. DATE SIGNED: 2/25/60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 2-29-60
23c. NAME OF CEMETERY OR CREMATORY: Washington Park
23d. LOCATION (City, town, or county) (State): St Louis County Mo.
24. FUNERAL DIRECTOR: J. McClendon ADDRESS: 4535 Washington Mo.
25. DATE RECD. BY LOCAL REG.: FEB 26 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. L.P.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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_____

Licensed Embalmer No. 5072

P. O. Address 4530 WA

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