URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-009105

STATE FILE NUMBER

FILED VS MAR 11 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 2094

NDED

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

c. CITY OR TOWN St. Louis | Inside Limits Yes ☐ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) DOA City Hosp II | Inside Limits Yes ☐ No ☐

d. STREET ADDRESS 4854 (If outside, give location) Kossuth | Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Fericio Middle Pablo Last Yanez

4. DATE OF DEATH Month Feb. Day 19 Year 1960

5. SEX male

6. COLOR OR RACE American Negro

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH 8 Nov. 1894

9. AGE (last birthday) 65 | 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) retired

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Metropolis Ill.

12. CITIZEN OF WHAT COUNTRY U.S.

13a. FATHER'S NAME unk

13b. MOTHER'S MAIDEN NAME unk

14. NAME OF HUSBAND OR WIFE XXXX

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. 492-05-7209

17. INFORMANT Vera Stone 4854 Address Kossuth

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteria Scleratic Heart

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

DUE TO (b)

DUE TO (c) 420.0

INTERVAL BETWEEN ONSET AND DEATH

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 _____ to _____ and last saw her/him alive on _____

Death occurred at 155 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature]

22b. ADDRESS 1500 Clay

22c. DATE SIGNED 2/23/60

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

23b. DATE 24Feb.1960

23c. NAME OF CEMETERY OR CREMATORY Washington Park

23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.

24. FUNERAL DIRECTOR ADDRESS Reliable Funeral Sys. 1389 N.Union

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

26. REGISTRAR'S SIGNATURE Earl Smith M.D. L.P.

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

BY AFFIDAVIT OF 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_____ Signed Paul V. Freeman

Signature of Student Embalmer

Licensed Embalmer No. 4686

P. O. Address 1389 Um

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.