URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS APR 4 1960

60-012938

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 3109

NDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MISSOURI
Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION: BARNES HOSPITAL — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: Saint Louis — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 745 Walton Avenue — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First BERTHA — Middle NMN — Last MARTIN
4. DATE OF DEATH: Month MARCH — Day 14 — Year 1960
5. SEX: Female
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 8-22-1903
9. AGE (last birthday): 56
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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Carroll County, Miss. U. S. A.
12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME: Aaron Morehead
13b. MOTHER'S MAIDEN NAME: Maggie Beck
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.: 494-28-4475
17. INFORMANT: James Martin — Address: 745 Walton Avenue

MEDICAL CERTIFICATION

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)	ADVANCED RESPIRATORY INSUFFICIENCY	3 WEEKS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	VASCULAR ACCIDENT IN BRAIN STEM	3 WEEKS
DUE TO (c)	ADVANCED ARTERIOSCLEROSIS	20 YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
LEUTIC AORTITIS. ARTERIOLAR NEPHROSCLEROSIS

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 FEB. 26, 1958, to MARCH 14, 1960 and last saw her/him alive on MARCH 14, 1960
Death occurred at 4:00 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: G. Vermillion, M.D. (Degree or title) M. D.
22b. ADDRESS: BARNES HOSPITAL
22c. DATE SIGNED: 3/15/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 3-19-60
23c. NAME OF CEMETERY OR CREMATORY: Washington Park Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis County, Mo.
24. FUNERAL DIRECTOR: Metropolitan Funeral System, Inc. — ADDRESS: 5010 Enright
25. DATE RECD. BY LOCAL REG.: MAR 17 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

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 John K. Cummin

Licensed Embalmer No. 4476

P. O. Address 2405 Mo.

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.