

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS MAR 3 1 1960**

**60-013124**  
STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 3281**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>3 mo. 8 days</b>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Chronic Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>4553 Elmbank</b> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle Last <b>Richards</b>			4. DATE OF DEATH Month <b>3</b> Day <b>20</b> Year <b>60</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>col.</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/19/1889</b>	9. AGE (last birthday) <b>71</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Tenn.</b>	
12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME <b>Frank Patterson</b>		13b. MOTHER'S MAIDEN NAME <b>Melissa Thaplier</b>	
14. NAME OF HUSBAND OR WIFE <b>None</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <b>414 46 303a</b>	
17. INFORMANT <b>Bessie Dunn</b>		Address <b>3135 Marnice Pl.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pt. Bronchopneumonia</b>					INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>491x</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerotic Heart Disease - 3 mo.</b>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <b>12-11-59</b> to <b>3-20-60</b> and last saw her/him <b>3-20-60</b> Death occurred at <b>8:20 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>John W. Beckham, M.D.</b> (Degree or title)			22b. ADDRESS <b>5800 Arsenal</b>		22c. DATE SIGNED <b>3/21/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3/25/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		23d. LOCATION (City, town, or county) <b>St. Louis 22, Mo.</b> (State)	
24. FUNERAL DIRECTOR <b>Price Funeral Home</b>		ADDRESS <b>2829 Washington</b>		25. DATE RECD. BY LOCAL REG. <b>MAR 22 1960</b>	26. REGISTRAR'S SIGNATURE <b>Paul Smith M.D.</b>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 14 1960

**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 Edward Flynn

Licensed Embalmer No. 4444

P. O. Address St. Louis

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.