

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-016748

FILED VS MAY 13 1960

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STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4659 Labadie</b>
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>C</b> Last <b>Delaney</b>	4. DATE OF DEATH Month <b>4</b> Day <b>27</b> Year <b>60</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>25 July 90 69</b>	9. AGE (last birthday) <b>69</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>1</b>	IF UNDER 24 HR Hours <b>1</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Bank Messenger</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Frank Delaney</b>	13b. MOTHER'S MAIDEN NAME <b>Lillie First</b>	14. NAME OF HUSBAND OR WIFE <b>Mrs Mattie Delaney</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes One</b>	16. SOCIAL SECURITY NO. <b>496-18-1394</b>	17. INFORMANT <b>Mrs Mattie Delaney 4659 Labadie Ave</b>
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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) <b>Cerebral Thrombosis</b>		<b>Undet.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerosis</b>	<b>Undet.</b>
	DUE TO (c) <b>332x</b>	

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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
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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
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21. I attended the deceased from <b>4-22-60</b> to <b>4-27-60</b> and last saw him alive on <b>4-27-60</b> Death occurred at <b>11:45</b> <b>p.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Deceased or title) <b>Sydney A. Truesher, M. D.</b>	22b. ADDRESS <b>2601 N. Whittier St.</b>	22c. DATE SIGNED <b>4-28-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>5/2/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Jefferson Barracks</b>	23d. LOCATION (City, town, or county) (State) <b>Jefferson Barrack Missouri</b>
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24. FUNERAL DIRECTOR <b>Herman J. Smith 4247 1/2 Labadie</b>	25. DATE RECD. BY LOCAL REG. <b>APR 29 1960</b>	26. REGISTRAR'S SIGNATURE <b>Roan Smith M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

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 Thomas M. Hobbs

Licensed Embalmer No. 4479

P. O. Address 2305 7th St  
Crest Hill, Mo.

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.