

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS APR 18 1960

=60-017101

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 3813** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri.		c. CITY OR TOWN St. Louis	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Firmin Desloge Hospital		d. STREET ADDRESS (If outside, give location) 2721a Henrietta	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sylvia Middle McKenzie Last		4. DATE OF DEATH Month 3- Day 31 Year 60	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/16/1919
9. AGE (last birthday) 40		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 Homes	11. BIRTHPLACE (City and state or country) Arkansas.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME James A. Ward	
13b. MOTHER'S MAIDEN NAME Unavailable		14. NAME OF HUSBAND OR WIFE Unavailable	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Nil	
17. INFORMANT James A. Ward, Nimmons, Arkansas.		Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Necrotizing Papillitis <i>measles virus papillitis</i> Clinical imp. <i>clinical imp.</i>		INTERVAL BETWEEN ONSET AND DEATH 1 week
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Diabetes Mellitus DUE TO (c) diabetic mellitus 260+	
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ Month, Day, Year _____ s.m. _____ p.m. _____	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 March 1, 1960 to March 31, 1960 and last saw her March 31, 1960 alive on March 31, 1960 Death occurred at 11:35 11:25 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Jos. F. Carron (Degree or title) M.D.		22b. ADDRESS Desloge Hospital	22c. DATE SIGNED 3-31-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4/4/60	23c. NAME OF CEMETERY OR CREMATORY Local	23d. LOCATION (City, town, or county) (State) Piggott, Arkansas.
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.,	ADDRESS	25. DATE RECD. BY LOCAL REG. APR 5 1960	26. REGISTRAR'S SIGNATURE Paul Smith, M.D.

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

22183

VS APR 18-1960

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 Oliver R. Padua

Licensed Embalmer No. 407
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.