

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-017392

FILED VS APR 22 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 3999** STATE FILE NUMBER

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 <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5645 terry ave			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5645 terry ave		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Annie Middle R. Teasley Last				4. DATE OF DEATH Month 4 Day 10 Year 1960			
5. SEX Female	6. COLOR OR RACE negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 2-7-1915	9. AGE (last birthday) 45	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Cartersville Ga.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME William Washington			13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Dr. J. Teasley		
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.		17. INFORMANT Address Dr. J. Teasley 5645 terry ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism DUE TO (b) Metastatic Carcinoma DUE TO (c) Carcinoma of Left Breast. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 170X 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							INTERVAL BETWEEN ONSET AND DEATH
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 9-19-58 to 4-10-60 last saw her/him alive on 4-10-60 . Death occurred at 4-10-60 at 11:20 AM on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Cardwell J. Haffey, M.D.				22b. ADDRESS 2616 N. Kentucky		22c. DATE SIGNED 4-11-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) sh, pped	23b. DATE 4-12-1960	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) Cartersville, Ga.		(State)	
24. FUNERAL DIRECTOR ADDRESS Boyd Funeral Home 3704 Fomeny			25. DATE RECD. BY LOCAL REG. APR 11 1960		26. REGISTRAR'S SIGNATURE Earl Smith, M.D. mgb		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

(Licensed Embalmer's Statement on Reverse Side)

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 W. Claude Gaudin

Licensed Embalmer No. 3489

P. O. Address 1123 W. J.

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.