

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-020823

FILED VS. MAY 13 1960

318

Primary Registration District No. **1003**

Registrar's No. **4706**

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 915 N GRAND ST LOUIS MO		Length of stay in lb 24 yrs.		c. CITY OR TOWN ST LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETS ADMIN HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1527 MARCUS AVE.	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					

3. NAME OF DECEASED (Type or print) First JAMES Middle Last DAVIS			4. DATE OF DEATH Month April Day 30 Year 1960			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/26/13	9. AGE (last birthday) 46	IF UNDER 1 YEAR Months 7 Days 4	IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done or profession, occupation, or service if retired) SERV STA ATTENDANT	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) NATCHEZ, MISS.	12. CITIZEN OF WHAT COUNTRY USA
---	-----------------------------------	--	--

13a. FATHER'S NAME HENRY DAVIS	13b. MOTHER'S MAIDEN NAME JOSEPHINE CARRIDINE	14. NAME OF HUSBAND OR WIFE
---------------------------------------	--	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give dates of service) YES	16. SOCIAL SECURITY NO. 492-10-5558	17. INFORMANT JOSEPHINE DAVIS 1527 MARCUS ST LOUIS MO.
--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE BILATERAL PULMONARY EMBOLI		INTERVAL BETWEEN ONSET AND DEATH 5 MIN
DUE TO (b) _____		
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) GLIOBLASTOMA MULTIFORME INVOLVING LEFT CEREBRAL HEMISPHERE		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

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 3/4/60	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 VAH, ST LOUIS MO.	COUNTY _____ STATE _____
---	--	--	--	--------------------------

21. I attended the deceased from **3/4/60** to **4-30-60** and last saw him alive on **4-30-60**
Death occurred at **10:30 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) FRANKLIN H. PFEFFENBERGER M.D.	22b. ADDRESS VAH, ST LOUIS MO.	22c. DATE SIGNED 5-1-60
---	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5-5-1960	23c. NAME OF CEMETERY OR CREMATORY National	23d. LOCATION (City, town, or county) (State) Jefferson Barracks Mo.
---	------------------------------	---	--

24. FUNERAL DIRECTOR J. H. RANDLE & SON	ADDRESS 3133 Bell Ave.	25. DATE RECD. BY LOCAL REG. MAY 3 1960	26. REGISTRAR'S SIGNATURE Loel Smith, M.D.
---	----------------------------------	---	--

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

Esther K. Harris

Licensed Embalmer No. *4428*

P. O. Address *4181 3rd*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.