

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS JUN 27 1960

-60-025061

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5855** 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, MO.	Length of stay in 1b 4 yrs	c. CITY OR TOWN St. Louis	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. # 1.		d. STREET ADDRESS (If outside, give location) 4111 Washington Blvd.	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ISAIAH Middle WASHINGTON Last	4. DATE OF DEATH Month JUNE Day 5 Year 1960
--	---

5. SEX Male	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 June 3, 1913	9. AGE (last birthday) 47	IF UNDER 1 YEAR Months 0 Days 2	IF UNDER 24 HR Hours 0 Min. 0
-----------------------	----------------------------------	---	---	-------------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Winn, Arkansas	12. CITIZEN OF WHAT COUNTRY U. S. A.
--	-----------------------------------	---	--

13a. FATHER'S NAME Will Washington	13b. MOTHER'S MAIDEN NAME Pearl Orphan	14. NAME OF HUSBAND OR WIFE ?
--	--	---

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. 488-18-2681	17. INFORMANT John Schmitz 3949 Forest Park	Address
---	---	---	---------

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)	Hepatic coma	2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Primary carcinoma of the liver	unknown
	DUE TO (c) 155-D	

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
---	--

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 12:55 a.m. P Month, Day, Year 5/27/60	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 St. Louis Co.	COUNTY	STATE
--	--	--	--	--------	-------

21. I attended the deceased from 5/27/60 to 6/5/60 and last saw her/him alive on 6/5/60 Death occurred at 12:55 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Rausser P. Crahan Jr., M.D.	22b. ADDRESS 1515 LAFAYETTE AVE.	22c. DATE SIGNED 6/5/60
--	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6-8-1960	23c. NAME OF CEMETERY OR CREMATORY Father Dickson	23d. LOCATION (City, town, or county) St. Louis Co.	(State) Mo.
---	------------------------------	---	---	-----------------------

24. FUNERAL DIRECTOR J. H. RANDLE & SON	ADDRESS 3133 Bell Ave.	25. DATE RECD. BY LOCAL REG. JUN 7 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
---	----------------------------------	---	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

7

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. 445

P. O. Address 4181 7th

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