IRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS AUG 8 1960

Registrar's District No. 318 Primary Registration District No. 1003 Registrar's No. 7524 —60—028243 STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b: 4 mo.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Chronic Hospital — Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4300 W. Belle — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Jennie — Middle: — Last: DeHart

4. DATE OF DEATH: Month — Day — Year: 7-24-60

5. SEX: Female
6. COLOR OR RACE: Colored
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 1873
9. AGE (last birthday): 87
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): unk
10b. KIND OF BUSINESS OR INDUSTRY: unk
11. BIRTHPLACE (City and state or country): Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: George
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: ------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unk
(If yes, give war or dates of service): unk
16. SOCIAL SECURITY NO.: unk
17. INFORMANT: Chronic Hospital Address: 5800 Arsenal St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Left Middle Cerebral Artery Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Generalized Arteriosclerosis – 4 mo.

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 3-23-60, to 7-24-60 and last saw her/him alive on 7-24-60
Death occurred at 6:15 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John W. Beckham, M.D.
22b. ADDRESS: 5800 Arsenal
22c. DATE SIGNED: 7/25/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 7-30-60
23c. NAME OF CEMETERY OR CREMATORY: Father Dickson Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, Mo. Co.

24. FUNERAL DIRECTOR: A.E. Beal Und. Co.
ADDRESS: 4303 DeBar Blvd.
25. DATE RECD. BY LOCAL REG.: JUL 28 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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.

NOT EMBALMED• RECLAIMED BY U

Student_____ Signed_____ FROM ANATOMICAL BOAR

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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