

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028609

FILED VS. AUG 4 1960 18

1003

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **6987**

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| 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 lb Life | 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 Enroute to City Hosp. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (if outside, give location) 4456 Oakland Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|----------------------------------|---|---|-------------------------------------|--|--|
| 3. NAME OF DECEASED (Type or print) First LILLIE Middle L. Last MATH | | | 4. DATE OF DEATH Month 7 Day 10 Year 1960 | | | |
| 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 8/17/95 | 9. AGE (last birthday) 64 | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary | | 10b. KIND OF BUSINESS OR INDUSTRY Bell Telephone | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME William Baird | | 13b. MOTHER'S MAIDEN NAME Effie Childers | | 14. NAME OF HUSBAND OR WIFE | | |

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| 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 Lillie Terry, Kansas City, Mo. | Address |
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| 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) | Cardiac failure | 1 hr |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Hypertension | 1.5 yrs. |
| | DUE TO (c) 444x | |
| 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 |

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| 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 _____ e.m. _____ p.m. _____ | Month, Day, Year | |

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|--|--|---|--------|-------|
| 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, Mo. | COUNTY | STATE |
| 21. I attended the deceased from Sept. 1944 to July 10, 1960 and last saw her alive on July 10, 1960 . Death occurred at 7:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | |

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| 22a. SIGNATURE Pauline J. Johnson M.D. | (Degree or title) | 22b. ADDRESS 6400 Mugarford Rd | 22c. DATE SIGNED 7-11-60 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 7/11/60 | 23c. NAME OF CEMETERY OR CREMATOR St. Matthews Cem. | 23d. LOCATION (City, town, or county) (State) St. Louis, Mo. |

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| 24. FUNERAL DIRECTOR McLAUGHLIN'S, 2301 Lafayette | ADDRESS | 25. DATE RECD. BY LOCAL REG. JUL 12 1960 | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. |
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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 A. G. Francis

Licensed Embalmer No. 3384
P. O. Address A. 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.