

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS AUG 8 1960**

**-60-028829**

318 Primary Registration District No. 1003 Registrar's No. 7509

STATE FILE NUMBER

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis, Missouri</b>          |  | c. CITY OR TOWN <b>St. Louis, Missouri</b>  |  |
| Length of stay in 1b   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>4569 St. Ferdinand</b> |  | d. STREET ADDRESS (If outside, give location)<br><b>4569 St. Ferdinand</b>  |  |
| Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                                |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |

|  |                                  |   |  |   |  |
|--|----------------------------------|---|--|---|--|
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>James Lisbon Steele</b>                           |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>July 26, 1960</b> |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/4/1894</b>                        | 9. AGE (last birthday)<br><b>66</b>                                     | IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HR<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Care taker</b> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Deloge Med. School</b>  |  | 11. BIRTHPLACE (City and state or country)<br><b>Tuscumbia, Alabama</b> |  |
| 12. CITIZEN OF WHAT COUNTRY<br><b>U. S. A.</b>   |                                  | 13a. FATHER'S NAME<br><b>James F. Steel</b>   |  | 13b. MOTHER'S MAIDEN NAME<br><b>Ella</b>                                |  |
| 14. NAME OF HUSBAND OR WIFE<br><b>Junior Mae Steel</b>   |                                  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service)<br><b>Yes WW1</b>                                |  | 16. SOCIAL SECURITY NO.<br><b>345-01-8665</b>                           |  |
| 17. INFORMANT<br><b>Mrs. Junior Mae Steel</b>  |                                  | Address<br><b>4569 St. Ferdinand</b>  |  |   |  |

|  |                        |                                  |
|--|------------------------|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> |                        | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   | DUE TO (b) <b>331X</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) |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
|---|--|--|--|

|   |   |  |       |
|---|---|--|-------|
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour Month, Day, Year<br>a.m. p.m.   | 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 \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

|   |  |                                    |  |   |
|---|--|------------------------------------|--|---|
| 22a. SIGNATURE (Degree or title)<br><b>Paul Johnson Deputy Broker</b> |  | 22b. ADDRESS<br><b>1300 Clark</b>  |  | 22c. DATE SIGNED<br><b>7/28/60</b>                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>           |  | 23b. DATE<br><b>7/8/1/60</b>       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>National Cemetery</b> | 23d. LOCATION (City, town, or county)<br><b>St. Louis, Missouri</b> |
| 24. FUNERAL DIRECTOR<br><b>E.B. Korce</b>                             |  | ADDRESS<br><b>1221 North Grand</b> | 25. DATE RECD. BY LOCAL REG.<br><b>JUL 28 1960</b>             | 26. REGISTRAR'S SIGNATURE<br><b>Paul Smith, M.D.</b>                |

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 *William Blackman*

Licensed Embalmer No. 3962

P. O. Address 1721 N.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.