

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>6 mo 21</u>	c. CITY OR TOWN <u>St. Louis</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chronic Hosp.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1710 N. 10th St.</u>
3. NAME OF DECEASED (Type or print) First <u>Rosie</u> Middle <u>Arnold</u> Last		4. DATE OF DEATH Month <u>8</u> Day <u>5</u> Year <u>60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-30-08</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>51</u>
11. BIRTHPLACE (City and state or country) <u>Miss.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA.</u>	
13a. FATHER'S NAME <u>Edmond</u>		13b. MOTHER'S MAIDEN NAME <u>Rosie Craft</u>	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)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Hospital Records 5600 Arsenal</u>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PT. Middle Cerebral Artery Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 Days.</u>
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) <u>Diabetes Mellitus - 6 1/2 mo.</u>		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 _____ a.m. _____ p.m. _____	Month, Day, Year		
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 <u>1-14-60</u> to <u>8-5-60</u> and last saw her/him alive on <u>8-5-60</u>		Death occurred at <u>2:20 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) <u>John W. Beckham, M.D.</u>	22b. ADDRESS <u>5800 Arsenal</u>	22c. DATE SIGNED <u>8/5/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>AUG 31 1960</u>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>
23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u>		(State)

24. FUNERAL DIRECTOR <u>Rowland Mortuary Svc. 4104-06 Manchester</u>	25. DATE RECD. BY LOCAL REG. <u>AUG 18 1960</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.