

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040391

FILED VS OCT 21 1960

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10140** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri</b>		Length of stay in 1b <b>1 Week</b>	c. CITY OR TOWN <b>East St. Louis</b>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1129 Tudor Avenue</b>

3. NAME OF DECEASED (Type or print)	First <b>FRANK</b>	Middle <b>WITHERSPOON</b>	Last	4. DATE OF DEATH	Month <b>OCTOBER</b>	Day <b>17</b>	Year <b>1960</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/9/07</b>	9. AGE (last birthday) <b>53</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Central Drug</b>	11. BIRTHPLACE (City and state or country) <b>Sheppard, Ark.</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
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13a. FATHER'S NAME <b>GREEN WITHERSPOON</b>	13b. MOTHER'S MAIDEN NAME <b>SARAH ELLA STOKES</b>	14. NAME OF HUSBAND OR WIFE <b>MARY WITHERSPOON</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Mary Witherspoon, 1129 Tudor Ave.</b>	Address <b>E. St. Louis</b>
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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)	<b>Congestive Heart Failure</b>	
DUPLICATE (b)	<b>Aortic Insufficiency</b>	
DUPLICATE (c)	<b>Leuetic Heart Disease</b>	<b>0.23X</b> years

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"/> N. <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour <b>1:15 p.m.</b> 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
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21. I attended the deceased from <b>3/25/60</b> to <b>10/17/60</b> and last saw him <b>10/17/60</b> Death occurred at <b>1:15 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>C. O. Vermillion, M.D.</i> <b>C. O. Vermillion, M. D.</b>	22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>10/18/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10/22/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Gardens</b>	23d. LOCATION (City, town, or county) (State) <b>Stookey Township, Ill.</b>
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24. FUNERAL DIRECTOR <i>Marion O'Brien</i> <b>2114 Missouri E. St. Louis, Ill.</b>	25. DATE RECD. BY LOCAL REG. <b>OCT 19 1960</b>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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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 Frank Prako, Jr.

Licensed Embalmer No. 4356

P. O. Address St. 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.