

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District 1003 Registrar's No. 5480-61-022938 STATE FILE NUMBER

FILED JUN 16 1961

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Saint Louis</u>		Length of stay in 1b <u>40 yrs.</u>		c. CITY OR TOWN <u>Saint Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Peoples Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4106 Enright, Apt. A</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle Last <u>MIXON</u>				4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>11/23/83</u>		9. AGE (last birthday) <u>77</u> 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) <u>Moulder</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Scullin Steel</u>		11. BIRTHPLACE (City and state or country) <u>Lowns Co., Miss.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Mose Mixon</u>			13b. MOTHER'S MAIDEN NAME <u>Rebecca Hopkins</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) <u>no</u>			16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Ottawa Ward</u>		Address <u>4106 Enright, Apt A</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>C.A.C.A.</u> <u>vascular hypertension</u> DUE TO (b) <u>chr. bronchial asthma</u> DUE TO (c) <u>Chronic Bronchial Asthma 241+</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH	
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"/> No <input type="checkbox"/> Unknown			
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 Month, Day, Year a.m. p.m.									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>4-6-61</u>		20f. CITY, TOWN, OR LOCATION <u>6-8-61</u>		COUNTY STATE			
21. I attended the deceased from <u>4/16/61</u> to <u>6/9</u> and last saw her/him alive on <u>6/9/61</u> Death occurred at <u>St. Louis, Mo.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>W.C. Bridges M.D.</u>				22b. ADDRESS <u>4056 W. Bell</u>			22c. DATE SIGNED <u>6-12-61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>6/12/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>		23d. LOCATION (City, town, or county) <u>St. Louis Co., Mo.</u>			(State)	
24. FUNERAL DIRECTOR <u>Charles J. Gates, 4107 Finney</u>				25. DATE RECD. BY LOCAL REG. <u>JUN 12 1961</u>		26. REGISTRAR'S SIGNATURE <u>Head Smith M.D.</u>			

DATE AMENDED

7

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILE NO. SHOULD READ

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Rayton Swain

Licensed Embalmer No. **4580**

P. O. Address **4107 Finney**

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.