SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

FILED JUL 12 1961 Registration District No. 618 Primary Registration District No. 1003 Registrar's No. 5962

-61-022973
STATE FILE NUMBER

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Missouri
Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): BARNES HOSPITAL
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Illinois b. COUNTY: St. Clair
c. CITY OR TOWN: Lovejoy
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 129 N. 5th Street
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: SARAH Middle: NMN Last: NELSON
4. DATE OF DEATH: Month: JUNE Day: 24 Year: 1961
5. SEX: Female
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 7/20/1918
9. AGE (last birthday): 42
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): Como, Mississippi
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: WILLIE REYNOLDS
13b. MOTHER'S MAIDEN NAME: SUSIE HUNT
14. NAME OF HUSBAND OR WIFE: -----
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Sarah Ann Nelson, Address: 129 N. 5th St. Lovejoy, Illinois

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Renal Disease with Uremia — INTERVAL BETWEEN ONSET AND DEATH: 5 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Cardiovascular Disease — 5 years
DUE TO (c): 442+
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. ☐ Yes ☒ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 4/22/61, to 6/24/61 and last saw her alive on 6/24/61
Death occurred at 11:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): F R Bradley MD F. R. Bradley, M.D.
22b. ADDRESS: BARNES HOSPITAL
22c. DATE SIGNED: 6/24/61
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 7/2/1961
23c. NAME OF CEMETERY OR CREMATORY: Booker Washington
23d. LOCATION (City, town, or county) (State): Centreville Township, Ill.
24. FUNERAL DIRECTOR: Marion E. Officer ADDRESS: 2114 Missouri Ave. E. St. Louis, Ill.
25. DATE RECD. BY LOCAL REG.: JUN 27 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

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 Frank Prokopf

Licensed Embalmer No. 4356

P. O. Address St Louis, Mo

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.