

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No.

FILED FEB 2 - 1955

318

REG. DIST. NO. 1003 Registrar's No. 0485

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____				
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE				b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis				c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION Enterprise City Hospital				STREET ADDRESS (If rural, give location) 1124 So 4th St						
3. NAME OF DECEASED (Type or Print)		a. (First) Jessie		b. (Middle) James		c. (Last) Stevenson		4. DATE OF DEATH (Month) (Day) (Year) 1-18-55		
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Child		8. DATE OF BIRTH 12-30-1946		9. AGE (in years last birthday) 8 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child			10b. KIND OF BUSINESS OR INDUSTRY Child			11. BIRTHPLACE (City and State or Foreign Country) Fryers Point Miss		12. CITIZEN OF WHAT COUNTRY? U.S. A		
13a. FATHER'S NAME Robert Malone			13b. MOTHER'S MAIDEN NAME Isola Neal			14. NAME OF HUSBAND OR WIFE Isola Neal			mother	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Child			16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Isola Stevenson 1124 So 4th				ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Fracture of skull; Subdural Hemorrhage, suffered when struck by car, operated by one James Gessner, front of car at 1124 South Broadway about 1146 pm., Jan 13 1955.						INTERVAL BETWEEN ONSET AND DEATH		
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.								
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Accident						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT (Specify) SUICIDE HOMICIDE Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) Street		21c. (CITY, TOWN, OR TOWNSHIP) St. Louis		(COUNTY) Mo		(STATE)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Jan 13 55 11 p		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? E8124						
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above. 25										
23a. SIGNATURE Patrick Taylor Corvener					(Degree or title)		23b. ADDRESS 1300 CLARK		23c. DATE SIGNED 1.17.55.	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1-18-55		24c. NAME OF CEMETERY OR CREMATORY Oakdale		24d. LOCATION (City, town, or county) Lemay		(State) MO		
DATE REC'D BY LOCAL REG. JAN 17 1955		REGISTRAR'S SIGNATURE J. Carl Smith M.D.			25. FUNERAL DIRECTOR'S SIGNATURE A. H. Burks Undertaker 2506 Franklin Ave					

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 *Leroy H. Fannin*

Licensed Embalmer No. *45*

P. O. Address *3880 Ea*

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.