

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15789

State File No.

FILED APR 25 1957

BIRTH NO. REG. DIST. NO. 117 PRIMARY REG. DIST. NO. 100 Registrar's No. 753

1. PLACE OF DEATH a. COUNTY <u>Rural</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Koch, Mo</u>	c. LENGTH OF STAY (in this place township) <u>408 days</u>	c. CITY OR TOWN <u>St. Louis</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>4073 Lincoln</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Ora</u>	b. (Middle) <u>Lee</u>	c. (Last) <u>SYKES</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>3-17-57</u>
5. SEX <u>Fem</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED <u>Separated</u>	8. DATE OF BIRTH <u>2-25-92</u>
9. AGE (In years) (last birthday) <u>65</u>		IF UNDER 1 YEAR Months <u>20</u> Days	IF UNDER 24 HRS. Hours <u>20</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Nil</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>TENN.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Thomas Warren</u>	13b. MOTHER'S MAIDEN NAME <u>Emma Clay</u>	14. NAME OF HUSBAND OR WIFE <u>Willie Sykes</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) <u>No</u> (If yes, give way or dates of service)	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Records at Koch Hospital, Koch,</u>

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Diabetes Mellitus with</u>		<u>Diabetes</u>
	ANTECEDENT CAUSES DUE TO (b) <u>Chronic Glomerular Nephritis</u>		<u>4 yrs</u>
DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		<u>?</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Pleural Effusion & Ascites</u>		<u>18 Mos</u>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-3-56, 1956, to 3-17, 1957 that I last saw the deceased alive on 3-17-57, and that death occurred at 8:10 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Paul G. Russell</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Robert Koch Hospital</u>	23c. DATE SIGNED <u>3-18-57</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>3-23-57</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oakdale Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Lemay, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>3-21-57</u>	REGISTRAR'S SIGNATURE <u>Herbert B. Lombardi</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thomas Jackson 2726 Dickson</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Tel-9569

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.....

Licensed Embalmer No. 4476

P. O. Address 2405 Moran

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.