

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

57-022469
STATE FILE NUMBER
5842

FILED JUL 5 1957

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 5842

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital			Length of stay in lb 25 hrs	d. STREET ADDRESS 516 So Ewing	
3. NAME OF DECEASED (Type or print) First Joseph Middle Duff Last			4. DATE OF DEATH Month June Day 21, Year 1957		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 2 1953	9. AGE (In years last birthday) 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Alonza Duff			14. MOTHER'S MAIDEN NAME Ozell Washington		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address Alonza Duff 516 So Ewing		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status Epilepticus. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Encephalopathy DUE TO (c) 3532 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
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 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	
21. I attended the deceased from 6-20-57 to 6-21-57 and last saw him alive on 6-21-57 Death occurred at 2:47p m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) M. B. Avery M.D.			22b. ADDRESS 1515 Lafayette		22c. DATE SIGNED JUN 24 '57
23a. BURIAL, CREMATION, etc. (Specify)	23b. DATE 6-24-57	23c. NAME OF CEMETERY OR CREMATORY Oakdale		23d. LOCATION (City, town, or county) (State) Lema Mo St. Louis MO	
24. FUNERAL DIRECTOR S. J. Watson		ADDRESS 2769 Chouteau Ave.		25. DATE RECD. BY LOCAL REG. JUN 24 '57	26. REGISTRAR'S SIGNATURE Carl Smith M.D.

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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..... S. J. Watson.....

Licensed Embalmer No.. 269

P. O. Address.. 2769 Chou

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.