

Health,  
& Welfare  
S. Public  
th Service

FILED DEC 2 - 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42820  
STATE FILE NUMBER  
Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11226

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Missouri</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>ST CLAIR</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>		c. CITY OR TOWN <u>E. ST. LOUIS ILL</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MOPAC HOSP</u>		d. STREET ADDRESS (If outside, give location) <u>32 533 N 8th St.</u>	
Length of stay in lb <u>21 days</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ALEX</u> Middle <u>YATES</u> Last <u>YATES</u>			4. DATE OF DEATH Month <u>11</u> Day <u>21</u> Year <u>57</u>		
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5. SEX <u>M</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>SEP 17 1880</u>	9. AGE (In years last birthday) <u>77</u>	FUNDER 1 YEAR Months <u>2</u> Days <u>4</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GULF MOBILE OIL</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>PENSIONED</u>	11. BIRTH PLACE (City and state or country) <u>LOUISVILLE KY.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>NOT KNOWN</u>	13b. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>---</u>
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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. <u>918-10-4730</u>	17. INFORMANT <u>Cora Yates Collinsville Ill.</u>	Address <u>Collinsville Ill.</u>
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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>UREMIA.</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) <u>Chronic Pyelonephritis.</u> DUE TO (c) <u>600.0</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		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.)
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20c. TIME OF INJURY Hour <u></u> Month, Day, Year a.m. <u></u> p.m. <u></u>	20d. INJURY OCCURRED WHILE AT <input checked="" type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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
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21. I attended the deceased from <u>11-10-57</u> to <u>11-21-57</u> and last saw her/him alive on <u>11-21-57</u> Death occurred at <u>12:15 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>J. Anglen M.D.</u> (Degree or title)	22b. ADDRESS <u>MO Pacific Hosp.</u>	22c. DATE SIGNED <u>11-22-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>11/21/57</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <u>East St. Louis Ill.</u>
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24. FUNERAL DIRECTOR <u>John J. Kassly</u>	ADDRESS <u>E. St. Louis, Ill.</u>	25. DATE RECD. BY LOCAL REG. <u>NOV 22 '57</u>	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 Not Embalmed....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed John Kelly.....

Licensed Embalmer No. 68855  
P. O. Address C. St. Louis

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.