

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-012524
STATE FILE NUMBER
2421

FILED MAR 19 1958

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

300
-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTE 3178 Easton		d. STREET ADDRESS (If outside, give location) 3178 Easton	
3. NAME OF DECEASED (Type or print) First Middle Last Calvin Wynne		4. DATE OF DEATH Month Day Year February 25, 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1902
9a. AGE (In years last birthday) 55	9b. MONTHS	9c. DAYS	9d. HOURS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Starksville, Miss.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Cate Wynne	13b. MOTHER'S MAIDEN NAME Della Lawrence	14. NAME OF HUSBAND OR WIFE Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 430-36-6295	17. INFORMANT Address Martha Johnson 3178 Easton	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho Pneumonia</i>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			491x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)		
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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>T. Taylor Coroner</i>		22b. ADDRESS 1300 Clark	22c. DATE SIGNED 2-27-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2/28/58	23c. NAME OF CEMETERY OR CREMATORY Forest City	23d. LOCATION (City, town, or county) (State) Arkansas
24. FUNERAL DIRECTOR <i>B. Boone</i>	ADDRESS 1221 N. Grand	25. DATE RECD. BY LOCAL REG. FEB 27 '58	26. REGISTRAR'S SIGNATURE <i>Carl Smith</i>

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 *James C. Brown*

Licensed Embalmer No. *4755*

P. O. Address *1221 N. 1st St.*

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.