

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-031184  
STATE FILE NUMBER

FILED AUG 22 1958 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2090

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clayton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Olivette</b> 4380 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>County Hospital</b>		Length of stay in lb <b>DOA</b>	d. STREET ADDRESS (If outside, give location) <b>#12 Pricemont Dr.</b> Reside on Farm? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANCES HICKS EAST</b>			4. DATE OF DEATH Month Day Year <b>August 7, 1958</b>		
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5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-30-1910</b>	9. AGE (In years last birthday) <b>47</b>	10. FUNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	11. BIRTHPLACE (City and state or country) <b>Jackson, Miss.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Charles Hicks</b>	13b. MOTHER'S MAIDEN NAME <b>Julia Ella Magruder</b>	14. NAME OF HUSBAND OR WIFE <b>Robert B. East</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mr. Robert B. East, above</b>
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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) <b>Overdose of self-administered medication</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b)	<b>970.9</b>	
DUE TO (c)		
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 type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Self ingested overdose of medication</b>
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20c. TIME OF INJURY <b>3:00 P.M. 8/8/58</b>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>car in basement garage</b>	20f. CITY, TOWN, OR LOCATION <b>Olivette</b>	COUNTY <b>St. Louis</b>	STATE <b>Mo.</b>
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21. I attended the deceased from <b>of home</b> , to _____ and last saw <sup>her</sup> <sub>him</sub> alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.		
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22a. SIGNATURE (Degree or title) <b>Herbert B. Donahue</b> Coroner <b>3</b>	22b. ADDRESS <b>Clayton, Mo.</b>	22c. DATE SIGNED <b>8/18/58</b>
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23a. BURIAL, CREMATION, etc. (Specify) <b>Removal to</b>	23b. DATE <b>8-12-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>JAY B. SMITH, Maplewood, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>8-11-58</b>	26. REGISTRAR'S SIGNATURE <b>Herbert B. Donahue M.D.</b>
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Social, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

300  
1-57

84

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 *J Allen Davis*  
Licensed Embalmer No. *4953*  
P. O. Address *W L*

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.