Health, Welfare Public Service

601

300 1-56

2009

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

49607-58

58-045351

STATE FILE NUMBER

FILED JAN 14 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12807

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis Mo — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 25 Hon fa = 1 — Length of stay in 1b
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo — b. COUNTY
c. CITY OR TOWN St Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 22 800 So. 22nd — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Tyrone Middle Last Abrams
4. DATE OF DEATH Month 12 Day 4 Year 58
5. SEX Male 2
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 2-20-1958
9. AGE (In years last birthday) IF UNDER 1 YEAR Months 4 Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (Give state or country) St Mo.
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME Donald Abrams
14. MOTHER'S MAIDEN NAME Rosie Lee Cash
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Mk
16. SOCIAL SECURITY NO. Mk
17. INFORMANT Address Mc Taylor St 1300 Clark

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Bronchopneumonia
DUE TO (c) N.M.A.
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 491X
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 5, to and last saw her/him alive on
Death occurred at 8 am on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph M Quinn Deputy Coroner
22b. ADDRESS 1300 Clark
22c. DATE SIGNED 12/18/58

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE 1-31-59
23c. NAME OF CEMETERY OR CREMATORY Anatomical Board
23d. LOCATION (City, town, or county) (State) St. Louis, Mo.

24. FUNERAL DIRECTOR ADDRESS Rowland-Aker Mortuary Service 4104 Manchester Ave. St. Louis 10, Mo
25. DATE RECD. BY LOCAL REG. JAN 8 '59
26. REGISTRAR'S SIGNATURE J Carl Smith MD MJB

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.