

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045459

STATE FILE NUMBER

12041

FILED DEC 22 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>SAINT LOUIS</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR ST. INSTITUTION <i>ST. LOUIS CITY HOSP #1</i>		Length of stay in lb <i>22 1/2</i>	d. STREET ADDRESS # (If outside, give location) <i>#5 N. 22nd. Street</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>SADIE</i> Middle Last <i>BROWN</i>			4. DATE OF DEATH Month <i>DEC.</i> Day <i>12,</i> Year <i>1958</i>		
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5. SEX <i>Female</i> ³	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-6-12</i>	9. AGE (In years last birthday) <i>46</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (City and state or country) <i>Pine Bluff. Ark.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13a. FATHER'S NAME <i>Unknown</i>	13b. MOTHER'S MAIDEN NAME <i>Unknown</i>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go, or unknown) (If yes, give war or dates of service) <i>No.</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>EARL JOHNSON # 5.22 Street</i> Address
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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) <i>Acute Myelogenous Leukemia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 mon.</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) <i>204-3</i>	
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"/>

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 <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
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21. I attended the deceased from *12/8/1958* to *12/12/1958* and last saw ^{her}him alive on *12/12/1958*
Death occurred at *11 p.m.* m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>John Holt</i> (Degree or title) <i>M.D. c</i>	22b. ADDRESS <i>1515 Lafayette ave.</i>	22c. DATE SIGNED <i>12/12/58</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>12-16-58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Washington Park</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis, County, Mo.</i>
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24. FUNERAL DIRECTOR <i>SWAN - MCGHEE FUNERAL HOME</i>	25. DATE RECD. BY LOCAL REG. <i>DEC 15 '58</i>	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith Mo</i>
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

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 *Guyton Swan*

Licensed Embalmer No. *4580*

P. O. Address *4202 Fair*

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.