

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003685
STATE FILE NUMBER

FILED FEB 10 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 292

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Kinloch 4091</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis Co. Hospital</u> | | Length of stay in lb <u>2 DAYS</u> | d. STREET ADDRESS (If outside, give location) <u>640 Denham</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|----------------------------------|---|--|--|---|
| 3. NAME OF DECEASED (Type or print) <u>Baby Boy</u> First <u>Arbuthnot</u> Middle Last | | | 4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1959</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> 0 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-3-1959</u> | | 9. AGE (In years last birthday) IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | 11. BIRTHPLACE (City and state or country) <u>Clayton, Missouri, U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |

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|--|--|--|--|--|--|
| 13a. FATHER'S NAME <u>William Arbuthnot</u> | | 13b. MOTHER'S MAIDEN NAME <u>Ollie Taylor</u> | | 14. NAME OF HUSBAND OR WIFE <u>None</u> | |
| 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>None</u> | | 17. INFORMANT <u>St. Louis County Hospital</u> 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) <u>SUBARACHNOID HEMORRHAGE</u> DUE TO (b) <u>ALSO FOCAL ATELECTASIS -</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>From Birth</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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|---|--|--|--|--|--|
| 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 _____ a.m. _____ p.m. | | | | | |

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|---|--|--|--|---|-----------------------------------|
| 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 <u>1-3-1959</u> to <u>1-5-1959</u> and last saw him alive on <u>1-5-1959</u> Death occurred at <u>10:10 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <u>John G. Swan MD</u> (Degree or title) | | | 22b. ADDRESS <u>6015 S. BRENTWOOD BLVD.</u> | | 22c. DATE SIGNED <u>1-6-59</u> |

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|--|--|--|---|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 23b. DATE <u>1-30-59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Missouri Crematory</u> | | 23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u> |
| 24. FUNERAL DIRECTOR <u>County Hospital, Clayton</u> ADDRESS | | 25. DATE RECD. BY LOCAL REG. <u>1-30-59</u> | | 26. REGISTRAR'S SIGNATURE <u>John C. Murphy MD</u> | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

(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 embalmed 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. (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.