

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006846

STATE FILE NUMBER

2 1631

FILED MAR 2 1959

Registration District No.

Primary Registration District No.

Registrar's No.

300
-57
12
93
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. 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 INSTITUTION Firmin Desloge Hospital		d. STREET ADDRESS (If outside, give location) 2858 a Missouri, 18	
3. NAME OF DECEASED (Type or print) First Patricia Middle - Last Akers		4. DATE OF DEATH Month 2 Day 13 Year 59	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-11-59
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		9b. KIND OF BUSINESS OR INDUSTRY None	9c. AGE (In years last birthday) 13
10a. BIRTHPLACE (City and state or country) St. Louis, Mo.		10b. CITIZEN OF WHAT COUNTRY? U.S.A.	
11a. FATHER'S NAME Paul Ray Akers		11b. MOTHER'S MAIDEN NAME Mary Ann Catherine Swayne	
12a. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		12b. SOCIAL SECURITY NO. None	
13a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Atelant pneumonia</i>		13b. INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>pneumonia</i>		762.5	
DUE TO (c)		13c. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
14a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		14b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
15a. TIME OF INJURY Hour Month, Day, Year o.m. p.m.		15b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
16a. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		16b. CITY, TOWN, OR LOCATION COUNTY STATE	
17. I attended the deceased from <i>death</i> to <i>death</i> and last saw her alive on <i>2/11/59</i> Death occurred at <i>10</i> <i>A.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
18a. SIGNATURE <i>John R. Burkhardt M.D.</i> (Degree or title) C		18b. ADDRESS <i>Firmin Desloge Hosp</i>	
18c. DATE SIGNED <i>2/11/59</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. BURYAL (Specify) Removal	20b. DATE 2-17-1959	20c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	20d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri
21. FUNERAL DIRECTOR ADDRESS McLAUGHLIN'S, 2301 Lafayette Ave.		21b. DATE RECD. BY LOCAL REG. FEB 16 '59	21c. REGISTRAR'S SIGNATURE <i>Paul Smith, M.D.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

[Handwritten initials]

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 *H. G. Farris*

Licensed Embalmer No. *3384*

P. O. Address *St. Louis*

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.