

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007051

STATE FILE NUMBER 1130

RECORDED FEB 17 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

300  
1-57  
6  
91  
0

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>ST. LOUIS, MO.</i>		c. CITY OR TOWN <i>St Louis</i>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>ST. LOUIS CITY HOSPITAL</i>		d. STREET ADDRESS (If outside, give location) <i>820 N. Grand</i>			
3. NAME OF DECEASED (Type or print) First <i>Herbert T.</i> Middle <i>DRAKE</i> Last		4. DATE OF DEATH Month <i>2</i> Day <i>1</i> Year <i>1959</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>February 9, 1907</i>		
9. AGE (In years last birthday) <i>51</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed</i>	11. BIRTHPLACE (City and state or country) <i>Columbus, Ohio.</i>		
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13a. FATHER'S NAME <i>Pearl Drake</i>	13b. MOTHER'S MAIDEN NAME <i>Julia Leahy</i>		
14. NAME OF HUSBAND OR WIFE <i>None</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>Unknown</i>	16. SOCIAL SECURITY NO. <i>Unknown</i>		
17. INFORMANT Address <i>John Drake, Columbus, Ohio.</i>		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>Med. ect. t.'s - traumatic perforation of esophagus</i> DUE TO (b) <i>bleeding duodenal ulcer</i> DUE TO (c) <i>541.0</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>status post operative subtotal gastrectomy &amp; closure of esophageal perforation</i>		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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			
21. I attended the deceased from <i>1/28/59</i> to <i>2/1/59</i> and last saw her alive on <i>2/1/59</i> Death occurred at <i>8:15 A.M.</i> on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <i>Rhys A. Williams, M.D.</i>			
22b. ADDRESS <i>1515 LAFALETTE AVE.</i>		22c. DATE SIGNED <i>2-1-59</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>2-1-59</i>			
23c. NAME OF CEMETERY OR CREMATORY <i>St. Joseph's Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Columbus, Ohio.</i>			
24. FUNERAL DIRECTOR <i>Albert H. Hoppe, 4700 Washington Blvd.</i>		25. DATE RECD. BY LOCAL REG. <i>2-1-1959</i>			
26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>					

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

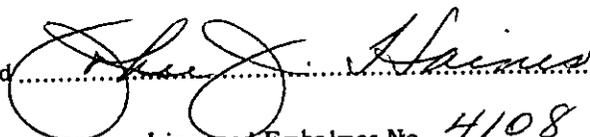
MEDICAL CERTIFICATION

Causes, however, etc. must use only standard nomenclature in Part 18. No symptoms will be stated. All diseases in Part I must be causally related.

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. 4108 .....

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.