

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007852

STATE FILE NUMBER

FILED MAR 2 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 379

300  
-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Clayton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Bellefontaine Neighbors</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. L. County Hosp.</b>		Length of stay in lb <b>D.O.A.</b>	d. STREET ADDRESS (If outside, give location) <b>9632 Colony Drive</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Alfred</b> Middle <b>S</b> Last <b>Garcia</b>			4. DATE OF DEATH Month <b>Feb</b> Day <b>8</b> Year <b>1959</b>		
-----------------------------------------------------------------------------------------------	--	--	--------------------------------------------------------------------	--	--

5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 3 1921</b>	9. AGE (In years) <b>38</b> (last birthday)	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
-----------------------	----------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------	------------------------------------------------	--------------------------------------------	--------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Universal Match Co</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
-----------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------	--------------------------------------------------------------------------	--------------------------------------------

13a. FATHER'S NAME <b>Vincent Garcia</b>	13b. MOTHER'S MAIDEN NAME <b>Amelia Simpson</b>	14. NAME OF HUSBAND OR WIFE <b>Helen Hofmann Garcia</b>
---------------------------------------------	----------------------------------------------------	------------------------------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, unknown) (If yes, give war or dates of service) <b>YES 2nd World War</b>	16. SOCIAL SECURITY NO. <b>495-18-8959</b>	17. INFORMANT <b>Mrs. Helen Garcia</b>	Address <b>9632 Colony Drive</b>
--------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------	-------------------------------------------	-------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4201</b>		

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.) <b>4201</b>
-----------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	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 <b>St. Louis</b>	COUNTY <b>Missouri</b>	STATE
---------------------------------------------------	--------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	--------------------------------------------------	---------------------------	-------

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at <b>10:30A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

22a. SIGNATURE (Degree or title) <b>John C. Murphy M.D. Acting Health Commissioner</b>	22b. ADDRESS <b>801 S. Brentwood Clayton</b>	22c. DATE SIGNED <b>2/26/59</b>
-------------------------------------------------------------------------------------------	-------------------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Feb. 11, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis Missouri</b>
-------------------------------------------------------------	-----------------------------------	---------------------------------------------------------------	--------------------------------------------------------------------

24. FUNERAL DIRECTOR <b>Math Hermann &amp; Son, Inc., 2161 E. Fair</b>	25. DATE RECD. BY LOCAL REG. <b>2-9-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>
---------------------------------------------------------------------------	-----------------------------------------------	---------------------------------------------------------

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 Clement M. Gray

Licensed Embalmer No. 3732

P. O. Address H. L. Lavin

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.