

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007939

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 424

1. PLACE OF DEATH
 a. COUNTY St. Louis
 b. CITY (If outside corporate limits, give TOWNSHIP only) Richmond Heights Inside Limits Yes No
 c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Marys Hospital Length of stay in lb Unknown

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Missouri b. COUNTY St. Louis
 c. CITY OR TOWN St. Louis Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 4915 Theodore Avenue Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First JAMES Middle MARRY Last WORD
4. DATE OF DEATH Month Feb. Day 12th Year 1959

5. SEX Male **6. COLOR OR RACE** White **7. MARRIED** NEVER MARRIED
 WIDOWED DIVORCED **8. DATE OF BIRTH** Aug. 19, 1883 **9. AGE** (In years, months, days) 75 (If UNDER 1 YEAR: Months 4 Days 15) (If UNDER 24 HRS.: Hours 1 Min. 0)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Movie Projectionist **10b. KIND OF BUSINESS OR INDUSTRY** Movie **11. BIRTHPLACE** (City and state or country) Rome, Georgia **12. CITIZEN OF WHAT COUNTRY?** USA

13a. FATHER'S NAME Arthur Word **13b. MOTHER'S MAIDEN NAME** Emily Papper **14. NAME OF HUSBAND OR WIFE** Agnes Word

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None **16. SOCIAL SECURITY NO.** Unknown **17. INFORMANT** Agnes Word Address 4915 Theodore Avenue

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Acute Tracheo-bronchitis INTERVAL BETWEEN ONSET AND DEATH 2 days
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) operation for cancer of 2 weeks
 DUE TO (c) Rectum, with bowel obstruction
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 154K **19. WAS AUTOPSY PERFORMED?** YES NO

20a. ACCIDENT **SUICIDE** **HOMICIDE** **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 NOT WHILE AT WORK **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 2/20/59 to 2/12/59 and last saw her alive on 2/12/59
 Death occurred at 2/12 St. Marys Hospital on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Francis J. Burns M.D. **22b. ADDRESS** 4660 Maryland St. Louis 8, Mo. **22c. DATE SIGNED** 2/13/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal **23b. DATE** 2/16/59 **23c. NAME OF CEMETERY OR CREMATORY** Calvary Cemetery **23d. LOCATION** (City, town, or county) (State) St. Louis, Missouri

24. FUNERAL DIRECTOR ADDRESS CALVIN F. FEUTZ, 4828 Natural Bridge Blvd., St. Louis, 15, Missouri **25. DATE RECD. BY LOCAL REG.** 2-13-59 **26. REGISTRAR'S SIGNATURE** John C. Murphy M.D.

300
-57
56
796

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 *John A. Mlenias*

Licensed Embalmer No. *4186*

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.