

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010837

STATE OF MISSOURI

REGISTRATION NUMBER
2-3122

FILED APR 10 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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-57

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|---|----------------------------------|---|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital | | Length of stay in lb 5 days | d. STREET ADDRESS 5505a Rhodes Ave. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Tobe Middle Last Daniels | | | 4. DATE OF DEATH March 26, 1959 Month Day Year | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 19, 1871 | 9. AGE (In years last birthday) 87 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) Retired Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | 11. BIRTHPLACE (City and state or country) Paragould, Arkansas | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13a. FATHER'S NAME William Daniels | | 13b. MOTHER'S MAIDEN NAME Elizabeth Palmer | | 14. NAME OF HUSBAND OR WIFE Addie Daniels | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Address Dwight Daniels, 9745 Lorna Lane | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident | | | | | INTERVAL BETWEEN ONSET AND DEATH 3/17/59 | |
| Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last. | | DUE TO (b) Advanced atherosclerosis | | | | |
| | | DUE TO (c) _____ | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 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 3/17/59 to 3/26/59 and last saw ^{him} alive on 3/26/59 Death occurred at 11:30 p.m. 3/26/59 m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | |
| 22a. SIGNATURE <i>John H. Guemler</i> (Degree or title) | | | 22b. ADDRESS 1504 So Grand Ave | | 22c. DATE SIGNED 3-27-59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 3-30-59 | 23c. NAME OF CEMETERY OR CREMATORY Shiloh Cemetery | | 23d. LOCATION (City, town, or county) (State) Paragould, Ark. | | |
| 24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd. | | | 25. DATE RECD. BY LOCAL REG. MAR 27 '59 | | 26. REGISTRAR'S SIGNATURE <i>Earl 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

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 *Stanley H. Dixon*
Licensed Embalmer No. *4193*
P. O. Address *St. L.*

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.