

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011439
STATE FILE NUMBER
2 2358

FILED MAR 27 1959

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

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO.</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP. #1.</u>		d. STREET ADDRESS (If outside, give location) <u>1217 (REAR) WRIGHT-ST</u>	
Length of stay in lb _____		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>AUGUST L. SUNDAY</u>			4. DATE OF DEATH Month Day Year <u>MARCH 5, 1959</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 10TH 1871</u>
9. AGE (In years last birthday) <u>87 YRS.</u>	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) <u>RETIRED-WATCHMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>	11. BIRTHPLACE (City and state or country) <u>MARYLAND-MO. 0</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>AUGUST-SUNDAY</u>	
13b. MOTHER'S MAIDEN NAME <u>CAROLINE-SCHMIDT.</u>		14. NAME OF HUSBAND OR WIFE <u>LOUISE-D.SUNDAY (DECD.)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>495-14-5722</u>	17. INFORMANT Address <u>OTTO-BAUER- 1630-KNAPP-ST.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO (c) <u>420.0</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Benign Prostatic Hyperplasia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Years</u>
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>JAN. 19, 1959</u> to <u>3/5/59</u> and last saw her alive on <u>3/5/59</u> Death occurred at <u>9:15 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>John F. Clisban M.D. - C</u>	
22b. ADDRESS <u>1515 LAFAYETTE AVE</u>		22c. DATE SIGNED <u>3/6/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>MAR 7TH 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BETHANY-CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS-COUNTY - MO.</u>
24. FUNERAL DIRECTOR <u>Brockland Und. Co.</u>		ADDRESS <u>1827-HOGAN-ST.</u>	
25. DATE RECD. BY LOCAL REG. <u>MAR 6 '59</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 *Robert M Murray*
Licensed Embalmer No. *3749*
P. O. Address *St. Louis, Mo.*

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.