

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014856

STATE FILE NUMBER

2 4110

FILED MAY 12 1959 Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St Louis</i>		c. CITY OR TOWN <i>St Louis</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Veteran Hospital</i>		d. STREET ADDRESS (If outside, give location) <i>1212 Armstrong</i>	
3. NAME OF DECEASED (Type or print) <i>Otho DANIELS</i>		4. DATE OF DEATH Month <i>4</i> Day <i>24</i> Year <i>59</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 26, 1919</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>National Lead Co. Laborer</i>		11. BIRTH PLACE (City and state or county) <i>Hattaburg Miss U. S. A.</i>	
13a. FATHER'S NAME <i>Brooks Daniels</i>		13b. MOTHER'S MAIDEN NAME <i>name forgotten</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <i>yes 4-1-42 12-3-45</i>		16. SOCIAL SECURITY NO. <i>425-28-3780</i>	
14. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congenital Berry Aneurysm of the right posterior cerebral artery with subarachnoid hemorrhage and infarction of the cerebral hemisphere</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>of the cerebral hemisphere</i>		DUE TO (c) <i>acute neurovascular</i>	
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 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.) <i>330x</i>	
20c. TIME OF INJURY Hour _____ 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 _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree of title) <i>Regina M. Smith</i>		22b. ADDRESS <i>1300 Clark</i>	
22c. DATE SIGNED <i>4/27/59</i>		23a. BURIAL, CREMATION, REMOVAL (Specify)	
23b. DATE <i>4-30-59</i>		23c. NAME OF CEMETERY OR CREMATORY <i>National Cemetery</i>	
23d. LOCATION (City, town, or county) (State) <i>Jefferson Barracks Co. Mo.</i>		24. FUNERAL DIRECTOR <i>Mrs. S. J. Nelson</i>	
25. DATE RECD. BY LOCAL REG. <i>APR 27 1959</i>		26. REGISTRAR'S SIGNATURE <i>Loan 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 *Fulton E. Culkin*

Licensed Embalmer No. *1098*
P. O. Address: *Thomas*

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.