

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015574
STATE FILE NUMBER
2 3694

FILED MAY 6 1959 Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

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1-57

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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 type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2725 Gamble | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) 2725 Gamble Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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|--|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last Thomas Pullian | | | 4. DATE OF DEATH Month Day Year April 11, 1959 | | |
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|----------------|---------------------------|---|-----------------------------------|---------------------------------------|--------------------------------|--------------------------------|
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 18, 1902 | 9. AGE (In years last birthday) 56 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
|----------------|---------------------------|---|-----------------------------------|---------------------------------------|--------------------------------|--------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (City and state or country) Mississippi | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
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| 13a. FATHER'S NAME Jack Pullian | 13b. MOTHER'S MAIDEN NAME Surrether Porter | 14. NAME OF HUSBAND OR WIFE None |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. Unknown | 17. INFORMANT Surrether Williams | Address 3015 Dickson |
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| 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>Coronary Occlusion</u> DUE TO (b) <u>Coronary Sclerosis</u> DUE TO (c) <u>420.1</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH |
| 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"/> |

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| 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.) |
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| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. |
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| 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 |
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at 945 A m on the date stated above; and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>Patrick Taylor Cornew</u> | 22b. ADDRESS <u>1300 Clark</u> | 22c. DATE SIGNED <u>4-14-59</u> |
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| 23a. BURIAL, CREMATION, REBURIAL (Specify) Burial | 23b. DATE 4/18/59 | 23c. NAME OF CEMETERY OR CREMATORY Washington Park | 23d. LOCATION (City, town, or county) (State) Berkley, Missouri |
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| 24. FUNERAL DIRECTOR <u>Carl B. Boone</u> | ADDRESS 1221 North Grand | 25. DATE RECD. BY LOCAL REG. APR 14 '59 | 26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u> |
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

mjc

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 Lawrence Cross

Licensed Embalmer No. 4755
P. O. Address 1221 N. W.

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.