

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015803
STATE FILE NUMBER
Registered No. 3216

FILED MAY 7 1959 Registration District No. Primary Registration District No. Register No. 3216

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair	
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 East St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's		Length of stay in 1b 1 week	d. STREET ADDRESS (If outside, give location) 1120 N. 2nd St
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Osver Straughter			4. DATE OF DEATH Month Day Year 3 29 59			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/15/1884	9. AGE (In years last birthday) 74	F UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 MRS.
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) Aberdeen, Miss.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Sam Straughter		13b. MOTHER'S MAIDEN NAME Easter Coffield		14. NAME OF HUSBAND OR WIFE Ussular Straughter		
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.	17. INFORMANT Ussular Straughter, Address 1120 N. 2nd E. St. Louis, Ill.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). cerebral hemorrhage			INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cerebral hemorrhage high blood pressure Hypertension			7 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 331X			
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"/> 2

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.) never injured			
20c. TIME OF INJURY Hour Month, Day, Year o.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 March 22 1959 to March 29 1959 and last saw her alive on March 29 1959		Death occurred at 11:30 P. m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE Dr. Earl Williams (Degree omitted) M.D.		22b. ADDRESS 501 North Lovejoy, Tallahassee, Fla.	
		22c. DATE SIGNED March 31, 1959	

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/4/59	23c. NAME OF CEMETERY OR CREMATORY Booker Washington		23d. LOCATION (City, town, or county) (State) Centreville Township, Ill.	
24. FUNERAL DIRECTOR Marion's Office East St. Louis, Ill.		ADDRESS 2114 Mo. Ave	25. DATE RECD. BY LOCAL REG. MAR 31 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

vertical writing, etc. must use only standard conventional ink and pen. No typewritten or printed matter to be inserted. All diseases in Part I must be causally related.

2180

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 *Frank Prohoff*

Licensed Embalmer No. *4356*

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.