

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015943

FILED MAY 6 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ STATE FILE NUMBER 2 3723  
Registration No. \_\_\_\_\_

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>St. Louis</b> TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Chronic Hosp.</b>		Length of stay in <sup>1b</sup> <b>3 weeks</b>	d. STREET ADDRESS (If outside, give location) <b>911 N. Beaubien Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Girlie</b> Middle Last <b>White</b>			4. DATE OF DEATH Month <b>4</b> Day <b>13</b> Year <b>59</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-17-1904</b>	9. AGE (In years last birthday) <b>54</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Miss.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13a. FATHER'S NAME <b>E. G. Pope</b>		13b. MOTHER'S MAIDEN NAME <b>Frances Williams</b>		14. NAME OF HUSBAND OR WIFE <b>--</b>	
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.		17. INFORMANT Address <b>Amory, Miss.</b> <b>William F. Pope 608-110th St</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pt. Middle Cerebral Art. Thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 mths.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Cerebral Arteriosclerosis</b>		<b>3 mths.</b>
	DUE TO (c) <b>Hypertensive Cardiovasc. Dis.</b>		<b>3 mths.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>443x</b>			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 WORK <input type="checkbox"/> 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 <b>3-23-59</b> to <b>4-13-59</b> and last saw her/him alive on <b>4-13-59</b> . Death occurred at <b>7:40 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <b>John W. Beckham, M.D.</b>		22b. ADDRESS <b>5800 Grand</b>		22c. DATE SIGNED <b>4/14/59</b>
BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)	
<b>AMORY MISS</b>	<b>4-15-59</b>	<b>Columbus, Concord, Lowndes</b>	<b>Miss.</b>	
24. FUNERAL DIRECTOR <b>Gustowe 2930 Dickson St.</b>	25. DATE RECD. BY LOCAL REG. <b>APR 15 59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>		

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Leroy U. Fannisto*

Licensed Embalmer No. *4523*

P. O. Address *4251 Washington*

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.