

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015949

STATE FILE NUMBER

2-2766

MAY 1 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 Mo b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital		d. STREET ADDRESS (If outside, give location) 5819 Cates Ave	
3. NAME OF DECEASED (Type or print) First Middle Last ROY CLIFFORD WHITTINGTON		4. DATE OF DEATH Month Day Year March 17, 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1987
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		9. AGE (In years last birthday) 71 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10. KIND OF BUSINESS OR INDUSTRY Katy R. R.	
11. BIRTHPLACE (City and state or country) Ind.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Whittington		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 486-01-2802	
17. INFORMANT Mrs. Roy Clifford Whittington		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Mycosis Fungoides DUE TO (c) Reticulum Cell Sarcoma			INTERVAL BETWEEN ONSET AND DEATH 2 weeks 5-6y
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 200.0			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.)
20c. TIME OF INJURY Hour Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <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 1/23/59 to 3/17/59 and last saw her/him alive on 3/16/59. Death occurred at 7:05 AM, m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) James C. Nishi, M.D.		22b. ADDRESS St Lukes Hosp	22c. DATE SIGNED 3/17/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE March 19/59	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
24. FUNERAL DIRECTOR ALEXANDER & SONS 6175 Delmar		25. DATE RECD. BY LOCAL REG. MAR 18 '59	26. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was examined by me, or by ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
*James E. McCulloch*

Licensed Embalmer No. 29

P. O. Address 61207

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.