

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015977
STATE FILE NUMBER

FILED MAY 11 1959

Registration District No. _____ Primary Registration District No. _____ Registrar 2-3832

300
1-57
91
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HOMER G. PHILLIPS</u>		Length of stay in lb _____	d. STREET ADDRESS (If outside, give location) <u>3200 LUCAS AVE</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELIZA</u> Last <u>LUCAS WILSON</u>			4. DATE OF DEATH Month <u>4</u> Day <u>14</u> Year <u>1959</u>			
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COL</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-8-1932</u>	9. AGE (In years last birthday) <u>26</u> 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) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>MONROE Miss.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>HOUSTON LUCAS</u>		13b. MOTHER'S MAIDEN NAME <u>MARY BELL RANDLE</u>		14. NAME OF HUSBAND OR WIFE <u>ELI WILSON</u>	
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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) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>MARY BELL LUCAS</u> Address <u>Box 14 Gibson Miss.</u>		
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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>Massive Intra Cerebral Hemorrhage</u> <u>Gunshot Wound of Chest</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: _____				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II as appropriate) <u>Shot in hand at 3200 Lucas Ave. about 7:10 am.</u>			
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20c. TIME OF INJURY Hour <u>7:10</u> a.m. Month, Day, Year <u>4 14 59</u>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>			
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20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <u>St. Louis Mo</u>		COUNTY _____	STATE _____
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21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.					
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22a. SIGNATURE <u>Lois Smith</u> (Deputy or Title) <u>Deputy</u>		22b. ADDRESS <u>1300 Clark</u>		22c. DATE SIGNED <u>4-15-59</u>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Amory Miss</u>		23b. DATE <u>4-19-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ABDEENE Miss.</u>		23d. LOCATION (City, town, or county) (State) <u>ABDEENE Miss.</u>
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24. FUNERAL DIRECTOR <u>Gus Lowe</u> ADDRESS <u>2930 Dickson St.</u>		25. DATE RECD. BY LOCAL REG. <u>4-18-1959</u>		26. REGISTRAR'S SIGNATURE <u>Lois Smith, M.D.</u>	
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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 John K Cunningham

Licensed Embalmer No. 4476

P. O. Address 4200 Hammett Pl

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.