

Health, Welfare
Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016007

STATE FILE NUMBER
REGISTRATION No. 3240

FILED APR 20 1959

Registration District No. Primary Registration District No.

300
-57
93
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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		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 5553 Maffitt	

3. NAME OF DECEASED (Type or print) Alice Yokely			4. DATE OF DEATH Month 3 Day 28 Year 59		
5. SEX Female	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 27 Apr. 1903	9. AGE (In years last birthday) 55	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Waco Tenn		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Early Wilson		13b. MOTHER'S MAIDEN NAME Mary Lizzie Frye		14. NAME OF HUSBAND OR WIFE xx	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) (If yes, give war or dates of service) no no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Ruby Walker 3951 Finney	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism			INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Arterial Fibrillation			
DUE TO (c) Arteriosclerotic Heart Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.0			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 a.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 **3-23-59**, to **3-28-59** and last saw her ^{her} _{him} alive on **3-28-59**
Death occurred at **7:20** **A** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE A. Inaker (Degree or title) 0	22b. ADDRESS M.D. 2601 Whittier Street	22c. DATE SIGNED 3-30-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 4 Apr. 1959	23c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co Mo.
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24. FUNERAL DIRECTOR ADDRESS Reliable Funeral Sys. 1389 N. Union	25. DATE RECD. BY LOCAL REG. APR 1 '59	26. REGISTERAR'S SIGNATURE Doyle Smith, M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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. *4746*
P. O. Address *2405 Mac*

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.