

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018930
State File No.

FILED JUN 4 1959

Registrar's No. 2 4930

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. 2 4930	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____			
b. CITY OR TOWN St. Louis 760		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2121 E Walnut				e. STREET ADDRESS (If rural, give location) 2121 E Walnut St			
3. NAME OF DECEASED (Type or Print)		a. (First) James		b. (Middle) _____		c. (Last) DEER	
4. DATE OF DEATH		(Month) 4 (Day) 25 (Year) 59		5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH _____		9. AGE (in years, Months, Days, Hours, Min.) 16		10. USUAL OCCUPATION (Give kind of work done during last year or even if retired) None	
10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and State or Foreign Country) Miss.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME W.L.K.	
13b. MOTHER'S MAIDEN NAME W.L.K.		14. NAME OF HUSBAND OR WIFE W.L.K.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME T. G. Aker		ADDRESS 1300 Clark		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES _____ DUE TO (b) Badly Badly decomposed DUE TO (c) apparently died from II. OTHER SIGNIFICANT CONDITIONS _____ Conditions contributing to the death but not related to the disease or condition causing death. Coronary Occlusion			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION Coronary Sclerosis		20. AUTOPSY? 3 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) 420.1		(COUNTY) _____ (STATE) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE James M. Smith (Degree or title) Deputy				23b. ADDRESS 1300 Clark		23c. DATE SIGNED 5/6/59	
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE 5-30-59		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. MAY 21 59		REGISTRAR'S SIGNATURE Loan Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Aker Mortuary Service		ADDRESS 4104 Manchester Ave. St. Louis 10, Mo.	

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.....

Licensed Embalmer No.....

P. O. Address

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.