

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019105

STATE FILE NUMBER
2 4012

FILED MAY 18 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		c. CITY OR TOWN <i>ST. LOUIS</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>5069 Kingsington</i>		d. STREET ADDRESS (If outside, give location) <i>5069 Kingsington</i>	
3. NAME OF DECEASED (Type or print) <i>CHARLIE</i>		4. DATE OF DEATH Month <i>4</i> , Day <i>21</i> , Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 16, 1867</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hub</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>92</i>
13a. FATHER'S NAME <i>Tom Dilworth</i>		13b. MOTHER'S MAIDEN NAME <i>Bettie ?</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>	17. INFORMANT <i>Emma Jones</i> Address <i>5767 Kingsington</i>
18. CAUSE OF DEATH (Not only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of Prostate, Uro-epithel</i>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <i>Remained in bed</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 _____ a.m. _____ p.m.			
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 <i>June 1958</i> to <i>4-21-59</i> and last saw her alive on <i>4-21-59</i> Death occurred at <i>4 p.m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>J. Smith M.D.</i>		22b. ADDRESS <i>3000 Easton Ave</i>	22c. DATE SIGNED <i>4-24-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<i>Removal</i>	<i>April 27/59</i>	<i>Hammond Cem</i>	<i>St Louis County Mo</i>
24. FUNERAL DIRECTOR <i>F. Green</i> ADDRESS <i>4214 Delmar</i>		25. DATE RECD. BY LOCAL REG. <i>APR 24 '59</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>

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 *F. A. Green*

Licensed Embalmer No. *2963*
P. O. Address *4214 DeMar*

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.