

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019410  
STATE FILE NUMBER  
2 4400

FILED MAY 18 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. \_\_\_\_\_

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1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Saint Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Saint Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Saint Mary's Infirmary</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>4120 Enright</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Edna</b> Middle <b>Ruth</b> Last <b>McGinnis</b>			4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 30, 1959</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hour <b>1</b> Min. <b>26</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>America</b>
13a. FATHER'S NAME <b>David McGinnis</b>		13b. MOTHER'S MAIDEN NAME <b>Ruth Johnson</b>		14. NAME OF HUSBAND OR WIFE <b>-</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Ruth McGinnis</b> Address <b>4120 Enright</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Inter-Uterine Pneumonia.</b> DUE TO (c) <b>763.0</b>					INTERVAL BETWEEN ONSET AND DEATH
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. 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 <b>April 30, 1959</b> to <b>April 30, 1959</b> and last saw her alive on <b>April 30, 1959</b> Death occurred at <b>2:48</b> A m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Pearl Adams M.D.</i>			22b. ADDRESS <b>4069<sup>a</sup> Easton Ave</b>		22c. DATE SIGNED <b>4/30/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
<b>Burial</b>		<b>5/5/1959</b>		<b>Calvary Cemetery</b>	
23d. LOCATION (City, town, or county) (State)					
<b>St. Louis, Missouri</b>					
24. FUNERAL DIRECTOR <b>Charles J. Gates</b>		ADDRESS <b>4107 Finney</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 5 '59</b>	
26. REGISTRAR'S SIGNATURE <i>Roal Smith, M.D.</i>					

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

30.

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 *Georgetown Swann* .....

Not Embalmed  
Licensed Embalmer No. ....  
P. O. Address...4107 Finney.....

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.