

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019877
STATE FILE NUMBER

FILED JUN 9 1959

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 1414

300
1-57
3

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirkwood		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kirkwood 46730 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 139 W. Peeke		Length of stay in 1b 30 yrs	d. STREET ADDRESS (If outside, give location) 139 W. Peeke Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First THOMAS Middle BARTHOLOMEW Last AUSTIN			4. DATE OF DEATH Month May Day 19 Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 6 1880
9. AGE (In years last birthday) 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	11. BIRTHPLACE (City and state or country) Pittsfield, Ill.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Derrick Rigger	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Tom Austin		13b. MOTHER'S MAIDEN NAME Nora Sigure	14. NAME OF HUSBAND OR WIFE Ida Austin
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give dates of service) No		16. SOCIAL SECURITY NO. 494-09-0743	17. INFORMANT Ida Austin-139 W. Peeke, Kirkwood Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intravascular accident (Coronary or C.V.D.)			INTERVAL BETWEEN ONSET AND DEATH immediate
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) arteriosclerosis			4500
DUE TO (c) 4500			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition listed in PART I. He had heart failure several yrs. Pt. would never be treated. Mr. Harris coroner, released.			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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw him alive on 19 May 59 Death occurred at 7 P.M. on the date stated above, to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>John Johnstone, Jr., M.D.</i> (Degree or title)		22b. ADDRESS 206 West Argonne	
22c. DATE SIGNED 21 May 59		23. NAME OF CEMETERY OR CREMATORY Calvary Cem.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE May 22, 1959	
23c. NAME OF CEMETERY OR CREMATORY Calvary Cem.		23d. LOCATION (City, town, or village) (State) St. Louis, Missouri	
24. FUNERAL DIRECTOR Pfzinger Mort-Kirkwood 22, Mo.		25. DATE RECD. BY LOCAL REG. 5-22-59	
26. REGISTRAR'S SIGNATURE <i>John B. Wainwright, M.D.</i>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Ben C. [Signature]*
Licensed Embalmer No. *436*
P. O. Address *[Signature]*

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.