Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

59-022817
STATE FILE NUMBER

FILED JUN 24 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 5631

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis, Mo — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 5064 Cabanne — Length of stay in 1b
1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 5064 Cabanne — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Minweria Middle Minervia Last Davis Davis
4. DATE OF DEATH Month June Day 9 Year 1959
5. SEX Female
6. COLOR OR RACE 3 Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Dec 18 1873
9. AGE (In years last birthday) 85 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours 6 Min. 50
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Miss
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Bill Morgan
13b. MOTHER'S MAIDEN NAME Sarah ?
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. —
17. INFORMANT Gorgie Parson Address 5056 Cabanne

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertension
DUE TO (c) Arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 443x
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 June 1. 59 to June 9. 59 and last saw her/him alive on June 9. 59
Death occurred at 8 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Walter A. Younge M.D.
22b. ADDRESS 4635 Easton.
22c. DATE SIGNED 6/11/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE June 15/59
23c. NAME OF CEMETERY OR CREMATORY Father Dickson
23d. LOCATION (City, town, or county) St Louis County (State)

24. FUNERAL DIRECTOR F. A. Green ADDRESS 4234 Delmar
25. DATE RECD. BY LOCAL REG. JUN 12 '59
26. REGISTRAR'S SIGNATURE Carl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 F. A. Green

Licensed Embalmer No. 2963

P. O. Address 4214 Delmar

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.