

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026593

FILED VS AUG 4 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2-6880** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b 2 1/2 Yrs.	c. CITY OR TOWN ST. LOUIS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1920, No. Whittier Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last BERTHA M. ELIJAH			4. DATE OF DEATH Month Day Year JULY 21 1959
5. SEX FEMALE	6. COLOR OR RACE COL.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/6/1929
9. AGE (last birthday) 29		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTICTS	11. BIRTHPLACE (City and state or country) ENGLAND ARKANSAS
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME FRED TOWNSEND	13b. MOTHER'S MAIDEN NAME ORA LEE GREEN
14. NAME OF HUSBAND OR WIFE FRANK ELIJAH		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NONE	16. SOCIAL SECURITY NO. ?
17. INFORMANT Address 1920, No. WHITE IER		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:	

IMMEDIATE CAUSE (a) LOWER NEPHRON NEPHROSIS	INTERVAL BETWEEN ONSET AND DEATH 4 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) LEFT LOWER LOBECTOMY	5 DAYS
DUE TO (c) MULTIPLE CYSTIC DISEASE OF LEFT LOWER LOBE	YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. 759.0 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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 **JUNE 7, 1959** to **JULY 21, 1959** and last saw her/him alive on **JULY 21, 1959**
 Death occurred at **6:50 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE C. D. Vermillion, M.D. (Degree or title)	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 7/22/59 (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 7/26/59	23c. NAME OF CEMETERY OR CREMATORY Herman dale Cemetery	23d. LOCATION (City, town, or county) HERMANDALE MISSOURI
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24. FUNERAL DIRECTOR John J. Houston ADDRESS 2812, THOMAS	25. DATE RECD. BY LOCAL REG. JUL 24 '59	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.
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DOCUMENT

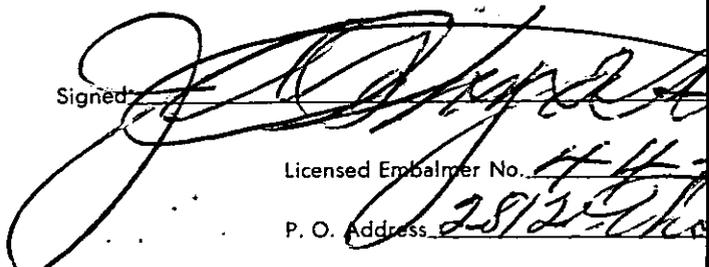
MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 447

P. O. Address 2812 [unclear]

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.