

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-026966

FILED VS AUG 5 1959

Registration District No. _____ Primary Registration District No. **2** STATE FILE NUMBER **7035** Registrar's No. _____

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57
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY St. Louis Mo		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Mo		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hoib Camelia		d. STREET ADDRESS (If outside, give location) Hoib Camelia	
3. NAME OF DECEASED (Type or print) Walter Mitchell		4. DATE OF DEATH 6 27 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH _____
9. AGE (In years last birthday) 71		IF UNDER 1 YEAR 71 Months	IF UNDER 24 HRS 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Walter	
13b. MOTHER'S MAIDEN NAME Walter		14. NAME OF HUSBAND OR WIFE Walter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) Walter		16. SOCIAL SECURITY NO. Walter	17. INFORMANT Walter Address 1300 Clark
18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive sub-acute Hemorrhage his location of neck (Fibrosarcoma) Suffered in fall down			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) Basement steps of home on June 26, 1959			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) Suffered in fall		
20c. TIME OF INJURY 6:26 p.m.	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Basement Steps at Home	20f. CITY, TOWN, OR LOCATION St. Louis 900.0 Mo	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21. I attended the deceased from _____, to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE Paul J. Simon (Degree) Deputy Coroner 3		22b. ADDRESS 1300 Clark	22c. DATE SIGNED 8/7/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Rowland-Aker Mortuary Service	23b. DATE 7-31-59	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) St. Louis, Mo.
24. FUNERAL DIRECTOR'S ADDRESS 1104 Manchester Ave. St. Louis 10, Mo.		25. DATE RECD. BY LOCAL REG. JUL 30 '59	26. REGISTRAR'S SIGNATURE Paul Smith, M.D.

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

Licensed Embalmer No.....

P. O. Address

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.