

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030348

FILED VS SEP 4 1959

2 7854

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 1 mo.	c. CITY OR TOWN St. Louis	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) 5972 Theodosia	
3. NAME OF DECEASED (Type or print) First Alice Middle B. Last Doell			4. DATE OF DEATH Month 8 Day 23 Year 59	
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-7-1872	9. AGE (last birthday) 86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Mo.	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME unk.		13b. MOTHER'S MAIDEN NAME Elsie ?		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. NONE	17. INFORMANT Address Lenna Cosmas 5972 Theodosia Av		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO (b) Coronary Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.1				INTERVAL BETWEEN ONSET AND DEATH old 1 mo. 1 mo.
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.	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 7-24-59 to 8-23-59 and last saw her/him alive on 8-23-59 Death occurred at 11:25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) John W. Beckhams M.D.		22b. ADDRESS 5800 Arsenal		22c. DATE SIGNED 8/24/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-26-59	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis Mo.	
24. FUNERAL DIRECTOR ADDRESS J.W.Clark F.H.1125 Hodiament Ave.		25. DATE RECD. BY LOCAL REG. AUG 24 '59	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

S.P.

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

Alfred J. Breda

Licensed Embalmer No. 266

P. O. Address 11257

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.