RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS AUG 18 1959

59-030835

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 7297

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 70 yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 1614 Texas Ave.
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 1614 Texas Ave.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: William Middle: A. Last: Sunshine
4. DATE OF DEATH: Month: August Day: 4 Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 10/24/78
9. AGE (last birthday): 80
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): Notary Public
10b. KIND OF BUSINESS OR INDUSTRY: Law
11. BIRTHPLACE (City and state or country): New Orleans, La.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: William Sunshine
13b. MOTHER'S MAIDEN NAME: Martha Vollrath
14. NAME OF HUSBAND OR WIFE: Alvina Sunshine
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Alvina Sunshire 1615 Texas Ave.

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): Debydration and Starvation — INTERVAL BETWEEN ONSET AND DEATH: 1 week
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Tumor of Oesophagus — 3 months
DUE TO (c): 150+
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I: arteriosclerotic heart disease, arteriosclerosis, chronic nephritis, Decubitus ulcers both buttocks, senility
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
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 July 8 1959, to Aug 4, 1959 and last saw ~~her~~ him alive on Aug 4, 1959
Death occurred at 2:20 a m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: Leroy E. Ellison (Degree or title) MD
22b. ADDRESS: 36 1050 Broadway St Louis, Mo
22c. DATE SIGNED: 8/4/59

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 8/6/59
23c. NAME OF CEMETERY OR CREMATORY: St. Matthews Cem.
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.
24. FUNERAL DIRECTOR: Chulick Und. Co. ADDRESS: 1722 So. Jefferson
25. DATE RECD. BY LOCAL REG.: AUG 6 '59
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.
M. J. B.

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed V E Morris

Signature of Student Embalmer

Licensed Embalmer No. 33 6

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to cor
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.