URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS AUG 26 1959

59-031119
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. X 2404

NDED

1. PLACE OF DEATH
a. COUNTY: St. Louis

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri COUNTY:

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Koch
Length of stay in 1b: DAYS

c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☑ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Robt. Koch Hospital
Inside Limits: Yes ☑ No ☐

d. STREET ADDRESS: 216 N. Compton (If outside, give location)
Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: Alonzo Middle: Last: Redmond Jr.

4. DATE OF DEATH: Month: Aug. Day: 1, Year: 1959

5. SEX: Male

6. COLOR OR RACE: n-white COLORED

7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☒

8. DATE OF BIRTH: 4-9-16

9. AGE (last birthday): 43 yrs.

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): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Arkansas

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Alonzo Redmond Sr.

13b. MOTHER'S MAIDEN NAME: Josephine Perkins

14. NAME OF HUSBAND OR WIFE: Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 707-16-5213

17. INFORMANT: Address: Hospital record, Robt. Koch Hosp.

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): Massive Hemorrhage

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Ruptured esophageal varice

DUE TO (c):

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)

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 7-23-59, to 8-1-59 and last saw her/him alive on 8-1-59

Death occurred at 9:10 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Bernard Friedman, M.D.

22b. ADDRESS: Robert Koch Hospital

22c. DATE SIGNED: 8-2-59

23a. BURIAL, CREMATION, REMOVAL (Specify): ~~Removal~~

23b. DATE: 8/7/59

23c. NAME OF CEMETERY OR CREMATORY: Washington Park

23d. LOCATION (City, town, or county) (State): St. Louis, County, Mo

24. FUNERAL DIRECTOR: Grant Johnson ADDRESS: 4352 Wash. Blvd.

25. DATE REC'D BY LOCAL REG.: AUG 5 1959

26. REGISTRAR'S SIGNATURE: John G. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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_____ Signed Fred [illegible]

Signature of Student Embalmer

Licensed Embalmer No. 2963

P. O. Address 4214 [illegible]

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