

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033655

FILED VS SEP 29 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **8507**

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		c. CITY OR TOWN St. Louis	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. Homer Phillips Hosp.		d. STREET ADDRESS (If outside, give location) 2730 Gamble St.	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Clarence Chatman			4. DATE OF DEATH Month Day Year Sept, 10 1959			
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5. SEX Male	6. COLOR OR RACE Col.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/17/92	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months Days 1 23	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired R.R. Man.	10b. KIND OF BUSINESS OR INDUSTRY Penn. R.R.	11. BIRTHPLACE (City and state or country) Nashville, Tenn.	12. CITIZEN OF WHAT COUNTRY USA.
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13a. FATHER'S NAME Samuel Chatman	13b. MOTHER'S MAIDEN NAME Sarah Cohn	14. NAME OF HUSBAND OR WIFE None
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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. 716-01-9568	17. INFORMANT Address Mattie Reid 3729 Lake Park, Chic, Ill
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <i>massive intra-cranial hemorrhage;</i>		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>penetrating gunshot wound of nose and brain suffered when shot with gun in the hands of one</i>		
DUE TO (b) <i>Bzell Jones (col.) in home at 2730 Gamble Street about 7:20 p.m. Sept 10, 1959.</i>		
DUE TO (c) <i>Homicide</i>		

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. 781X <input type="checkbox"/> Yes <input 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 type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>See above</i>
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20c. TIME OF INJURY 7:20 p.m.	Month, Day, Year 9-10-59
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	20f. CITY, TOWN, OR LOCATION St. Louis, Missouri	COUNTY	STATE
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____.
Death occurred at **7:45 P.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Paul Simon</i>	(Date signed)	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 9/14/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/16/59	23c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.	23d. LOCATION (City, town, or county) St. Louis Co. Mo.

24. FUNERAL DIRECTOR Wright Funeral Home	ADDRESS 3100 Easton Ave.	25. DATE RECD. BY LOCAL REG. SEP 15 59	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Arthur L. J. J. J.

Licensed Embalmer No. 4221

P. O. Address 3101 EA

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.