URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS NOV 12 1959

59-037368

STATE FILE NUMBER

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210107

1. PLACE OF DEATH
a. COUNTY

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

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.

Length of stay in 1b: 5 Days

c. CITY OR TOWN St. Louis

Inside Limits: Yes # ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp. # 1

Inside Limits: Yes # No ☐

d. STREET ADDRESS (If outside, give location) 3712 Hebert St.

Reside on Farm: Yes # No #

3. NAME OF DECEASED (Type or print): First ELMER Middle J. Last AGLES

4. DATE OF DEATH: Month Nov. Day 2 Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. Married # Never Married ☐ Widowed # Divorced ☐

8. DATE OF BIRTH: 8)1)1896

9. AGE (last birthday): 63

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): Construction

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (City and state or country): St. Louis Mo.

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

13a. FATHER'S NAME: Olis Agles

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE: Mary E, Agles

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

16. SOCIAL SECURITY NO.: 494-03-5576

17. INFORMANT: Mary E. Agles Address: 3712 Hebert St.

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) Bleeding Esophageal Varices

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

DUE TO (b) Due to Cirrhosis of the Liver (Harmico)

DUE TO (c) Chronic Alcoholism 581.1

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): Convulsive Disorder

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 1029/59, to 11/2/59 and last saw ~~her~~ him alive on 11/2/59

Death occurred at 3:08 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Daniel S. Hellman MD

22b. ADDRESS: 1515 Lafayette Ave.

22c. DATE SIGNED: 11/2/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 11)5)59

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

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

24. FUNERAL DIRECTOR ADDRESS: Collier Mortuary, St. Ann, Mo.

25. DATE RECD. BY LOCAL REG.: NOV 4 1959

26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D. MDB

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Sheldon Collier

Signature of Student Embalmer

Licensed Embalmer No. 3382

P. O. Address St. Ann. M

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.