

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041732

FILED VS DEC 7 1959

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STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY <i>St. Louis</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST LOUIS</i>		Length of stay in 1b	c. CITY OR TOWN <i>OVERLAND</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>ST JOHN'S HOSPITAL</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>8306 EADS</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>MARY</i> Middle <i>DAVIS</i> Last <i>DAVIS</i>			4. DATE OF DEATH Month <i>OCT</i> , Day <i>30</i> , Year <i>1959</i>		
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>10/28/59</i>	9. AGE (last birthday) IF UNDER 1 YEAR Months <i>0</i> Days <i>2</i> Hours <i>0</i> Min.	IF UNDER 24 HR Hours <i>0</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>ST LOUIS MISSOURI</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
13a. FATHER'S NAME <i>JAMES DAVIS</i>		13b. MOTHER'S MAIDEN NAME <i>MARIE ANNE BARNETT</i>		14. NAME OF HUSBAND OR WIFE <i>_____</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT <i>JAMES DAVIS 8306 EADS OVERLAND MO.</i> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Atelactasis</i>					INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs.</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					<i>762.5</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Prematurity</i>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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 <i>10-28-59</i> to <i>10-30-59</i> and last saw her <i>alive</i> on <i>10-30-59</i> Death occurred at <i>8:15 p.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Thomas Hill</i> (Degree or title) <i>M.D.</i>		22b. ADDRESS <i>674 N. Grand</i>		22c. DATE SIGNED <i>10-30-59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>10/31/59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>CALVARY CEMETERY</i>	23d. LOCATION (City, town, or county) <i>ST LOUIS MISSOURI</i> (State)		
24. FUNERAL DIRECTOR <i>.STROOT - CARROLL 4600 NATURAL BRIDGE</i> ADDRESS		25. DATE RECD. BY LOCAL REG. <i>OCT 30 1959</i>	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i> <i>S.O.</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*Dr JH Lieb
Room 922
CMA Theatre Co.*

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.

Not Embalmed

Student _____
Signature of Student Embalmer

Signed *M W Ruetter*

Licensed Embalmer No. *4865*
P. O. Address *St Louis Mo*

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.