URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS DEC 7 1959

59-042610

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210907

MENDED

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 — Length of stay in 1b 3 2 years

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

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3201a Lucas — Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 3201a Lucas — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First FRANK Middle Last TERRY

4. DATE OF DEATH Month 11 Day 21 Year 1959

5. SEX Male

6. COLOR OR RACE Negro

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 1905

9. AGE (last birthday) 54

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) Cab Driver

10b. KIND OF BUSINESS OR INDUSTRY Marcella Cab Co.

11. BIRTHPLACE (City and state or country) Forest City, Ark.

12. CITIZEN OF WHAT COUNTRY U. S. A

13a. FATHER'S NAME William Terry

13b. MOTHER'S MAIDEN NAME Alice Boland

14. NAME OF HUSBAND OR WIFE -----

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. ——

17. INFORMANT Elizabeth Edwards Address 3201a Lucas

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CEREBRAL HEMORRHAGE	1 DAY
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	HYPERTENSION	3 YRS.
DUE TO (c)	ARTERIOSCLEROSIS 331X	3 YRS

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 JAN 1, 1956, to NOV. 21, 1959 and last saw her him alive on NOV. 18, 1959

Death occurred at 7 15 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Orville O. White M.D.

22b. ADDRESS 2100 Hudson Dr

22c. DATE SIGNED 11-23-59

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

23b. DATE 11/27/59

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) (State) Forest City, Ark.

24. FUNERAL DIRECTOR ADDRESS Charles J. Gates, 4107 Finney Ave.

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

26. REGISTRAR'S SIGNATURE Hal Smith. M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

MEDICAL CERTIFICATION

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 Guyton Swan

Signature of Student Embalmer

Licensed Embalmer No. 4580

P. O. Address 4107 Fann

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