

U R I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042801

FILED VS DEC 3 1959

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3089

12/9/59 308

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania COUNTY Dauphin	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton, Missouri.		c. CITY OR TOWN Harrisburg	
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 St. Louis County Hospital		d. STREET ADDRESS (If outside, give location) 227 Hummel Street.	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Mildred (aka) Middle L. Francis Last Logan Mildred (Logan) Reid a/k as Mildred Logan			4. DATE OF DEATH Month November Day 20 Year 1959		
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5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/10/1920	9. AGE (last birthday) 39	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HR Hours 0 Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Pembroke, Pennsylvania	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Calvin Logan	13b. MOTHER'S MAIDEN NAME Louise Koons	14. NAME OF HUSBAND OR WIFE Raymond Reid
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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 Nil	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Calvin Logan, 227 Hummel Street.	Address
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Multiple injuries, shock and hemorrhage		
DUE TO (b) _____		
DUE TO (c) _____		

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

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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) Passenger in car operated by husband
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20c. TIME OF INJURY Hour 1:30 a.m. <input checked="" type="checkbox"/> p.m. <input type="checkbox"/> Month, Day, Year 11/20/59	which was involved in auto collision
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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.) highway	20f. CITY, TOWN, OR LOCATION Bel-Ridge	COUNTY St. Louis	STATE Missouri
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21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Raymond H. Hard</i> (Degree or title) Coroner	22b. ADDRESS Clayton, Mo.	22c. DATE SIGNED 11/30/59
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal	23b. DATE 11/21/59	23c. NAME OF CEMETERY OR CREMATORY Shoops Cemetery	23d. LOCATION (City, town, or county) (State) Harrisburg, Pennsylvania
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24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington	ADDRESS	25. DATE RECD. BY LOCAL REG. 11-20-59	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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(Licensed Embalmer's Statement on Reverse Side)

3 AFR added BY AFFIDAVIT OF Funeral Director MEDICAL CERTIFICATION DOCUMENT

MS DEPT
RECEIVED

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 _____
Signature of Student Embalmer

Signed Stanley J. Hinkle

Licensed Embalmer No. 4596
P. O. Address St. Louis

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.