

JRL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 45 1 8 4

FILED VS JAN - 8 1960

211863

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 Illinois b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis,	Length of stay in lb 26 days	c. CITY OR TOWN East St. Louis,	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis-Little Rock Hospitals, Inc.,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2935 Market St.,
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Gordon Middle - Last Adams	4. DATE OF DEATH Month Dec. Day 20, Year 1959
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5. SEX Male	6. COLOR OR RACE Colored	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1901	9. AGE (last birthday) 58 yrs.	IF UNDER 1 YEAR Months _____ Days _____	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) Carman	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) Ruston, Louisiana	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME UNKNOWN	13b. MOTHER'S MAIDEN NAME LIZZIE (Unknown)	14. NAME OF HUSBAND OR WIFE Mary Boyd
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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. 340-05-5408	17. INFORMANT Mary B. Adams	Address 2935 Market E. St. Louis, 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: IMMEDIATE CAUSE (a) Uremia		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Hepato sclerosis	
	DUE TO (c) 446x	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertension, secondary to Renal Dis.		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 AN 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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 _____
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21. I attended the deceased from **Nov. 25, 1959** to **Dec. 20, 1959** and last saw her/him alive on **Dec. 20, 1959**
Death occurred at **8:25 P.M.,** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Charles Brown</i> (Degree or title)	22b. ADDRESS 1755 South Grand Blvd.,	22c. DATE SIGNED 12/21/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/27/59	23c. NAME OF CEMETERY OR CREMATORY Booker Washington	23d. LOCATION (City, town, or county) Controville Township, Ill.
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24. GENERAL DIRECTOR ADDRESS Officer Funeral Home	25. DATE RECD. BY LOCAL REG. DEC 22 1959	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 _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Frank Prokop

Licensed Embalmer No. 4356

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.