

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-016602

FILED VS. APR 29 1960

2 3728

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Lukes Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>401 Greeley</b>	
3. NAME OF DECEASED (Type or print) First <b>AMY</b> Middle <b>R.</b> Last <b>BENNETT</b>		4. DATE OF DEATH Month <b>Apr.</b> Day <b>1,</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-9-86</b>
9. AGE (last birthday) <b>73</b>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	
11. BIRTHPLACE (City and state or country) <b>Little Rock, Ark.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Charles R. Robertson</b>		13b. MOTHER'S MAIDEN NAME <b>Hulda Jane Pope</b>	
14. NAME OF HUSBAND OR WIFE <b>Lloyd B. Bennett</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>L. B. Bennett, 401 Greeley</b>		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) <b>Intracranial Hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Acute Thrombocytopenia</b> DUE TO (c) <b>Aplasia, Bone Marrow</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>10 days.</b> <b>10 days.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Bronchiectasis 299X</b>			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 checked="" type="checkbox"/> NO <input 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 <b>June 1959</b> to <b>April 1, 1960</b> and last saw her <b>April 1, 1960</b> Death occurred at <b>4:15 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>J. Keenan MD</b>		22b. ADDRESS <b>Webster Groves 19, Mo.</b>	
22c. DATE SIGNED <b>4/3/60.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>4-4-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kirkwood, Mo.</b>
24. FUNERAL DIRECTOR <b>Parker-Aldrich, Webster Groves</b>		25. DATE RECD. BY LOCAL REG. <b>APR 4 1960</b>	
26. REGISTRAR'S SIGNATURE <b>Roal Smith, M.D.</b>			

INDEXED

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 Leslie Welch

Licensed Embalmer No. 439

P. O. Address Water St

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.