

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 25 1960

-60-016653

Registration District No. _____ Primary Registration District No. _____ Registrar's **2 4085** STATE FILE NUMBER

| | | | | | | |
|---|---|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo. | | Length of stay in 1b 60 Yrs. | c. CITY OR TOWN St. Louis | | 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 City Hosp. # 1 | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 2133 Victor | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JOSEPHINE Middle Last BRUCE | | | 4. DATE OF DEATH Month April Day 12, Year 1960 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 11/21/72 | 9. AGE (last birthday) 87 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) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY self | 11. BIRTHPLACE (City and state or country) Unk. Illinois | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Scot Bruce | | 13b. MOTHER'S MAIDEN NAME Elvira Randolph | | 14. NAME OF HUSBAND OR WIFE None | | |
| 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. Unknown | 17. INFORMANT Address Rose Liles, Fayetteville, Ark. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - R+ Lower Lobe | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 490X | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Malnutrition, Dehydration, Chronic Brain Syndrome | | | | 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 4/6/60 to 4/12/60 and last saw her <input type="checkbox"/> alive on 4/12/60 Death occurred at 3:40 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | |
| 22a. SIGNATURE Emma W. Thompson M.D. (Degree or title) | | | 22b. ADDRESS 1515 Lafayette Ave. | | 22c. DATE SIGNED 4/13/60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 4/15/60 | 23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cem. | | 23d. LOCATION (City, town, or county) (State) St. Louis, Mo. | | |
| 24. FUNERAL DIRECTOR McLaughlin's, 2301 Lafayette ADDRESS | | 25. DATE RECD. BY LOCAL REG. APR 14 1960 | 26. REGULAR'S SIGNATURE Earl Smith, M.D. | | | |

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 James R. Ch...
Licensed Embalmer No. 45
P. O. Address St. J...

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.