

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-017490

FILED VS. MAY 13 1960

2 4509

STATE FILE NUMBER

MAILED

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 <i>MO.</i> b. COUNTY			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Length of stay in 1b		c. CITY OR TOWN <i>St. Louis</i>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>1105(A) N. 18th St.</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <i>1105 N. 18th St.</i>	
				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <i>MARY</i> Middle <i>Womack</i> Last <i>Womack</i>			4. DATE OF DEATH Month <i>APRIL</i> Day <i>25</i> Year <i>1960</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>2/20/1902</i>	9. AGE (last birthday) <i>58</i>	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) <i>Office Cleaner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Fox Theater</i>		11. BIRTHPLACE (City and state or country) <i>St. Louis Mo.</i>		12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>
13a. FATHER'S NAME <i>Samuel Jones</i>		13b. MOTHER'S MAIDEN NAME <i>Ella Woods</i>		14. NAME OF HUSBAND OR WIFE <i>MARGARET Womack</i>		
15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>487-26-4396</i>		17. INFORMANT <i>MARGARET Womack</i> Address <i>214 Dickson Apt. 1001</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <i>Coronary Sclerosis</i>		
DUE TO (c) <i>420.1</i>		
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 checked="" 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 _____ to _____ and last saw her/him alive on _____
Death occurred at *6:50 A* m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Patricia Taylor Connor</i>		22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>4-27-60</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>4/28/60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>WASHINGTON PARK</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis County, Mo.</i>	
24. FUNERAL DIRECTOR <i>Wm. Smith</i> ADDRESS <i>4019 Washington</i>		25. DATE RECD. BY LOCAL REG. <i>APR 27 1960</i>		26. REGISTRAR'S SIGNATURE <i>Karl Smith M.D.</i>

(Licensed Embalmer's Statement on Reverse Side)

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 W _____
Signature of Student Embalmer

Signed [Handwritten Signature] _____

Licensed Embalmer No. 43711
P. O. Address St. Louis

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