

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. SEP. 2 1960 **818**

1003

8357-60-032932
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 Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis		Length of stay in 1b		c. CITY OR TOWN Saint 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 4728 Lexington Ave.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4728 Lexington Ave.			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Susie Middle Stovall Last				4. DATE OF DEATH Month Aug. Day 22, Year 1960			
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 5-10-1892	9. AGE (last birthday) 68	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) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Topcola, Mississippi		12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME Will Blake			13b. MOTHER'S MAIDEN NAME Harriett Johnson			14. NAME OF HUSBAND OR WIFE Sam Stovall	
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. 409-52-7202		17. INFORMANT Address Mrs. Rosie L. Byndon 2621 Dickson			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage							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) 331 x		
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 8:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Gabriel Taylor Carraway (Degree or title)				22b. ADDRESS 1300 Clark			22c. DATE SIGNED 8-24-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-27-60	23c. NAME OF CEMETERY OR CREMATORY Father Dickson Cemetery		23d. LOCATION (City, town, or county) St. Louis County, Mo.		(State)	
24. FUNERAL DIRECTOR Metropolitan Funeral System, Inc.		ADDRESS 5010 Enright		25. DATE RECD. BY LOCAL REG. AUG 25 1960	26. REGISTRAR'S SIGNATURE Road 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

John K Cunningham

Licensed Embalmer No. 4476

P. O. Address 2405 Marcus Av

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.