

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		c. CITY OR TOWN St. Louis	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. City Hosp #2		d. STREET ADDRESS (If outside, give location) 3912 A. Finney Ave	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Minnie Middle Sherrell Last			4. DATE OF DEATH Month 9 Day 2 Year 60		
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/28/1905	9. AGE (last birthday) 54	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) School Nurse		10b. KIND OF BUSINESS OR INDUSTRY 495.42.0853		11. BIRTHPLACE (City and state or country) Mobile Alabama	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Budy Sherrell		13b. MOTHER'S MAIDEN NAME Robacker Hedgeman	
14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 495-42-0853	
17. INFORMANT Joe Ballariel		Address 3912 Finney Ave			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION DUE TO (b) ACUTE HYPERTENSION DUE TO (c) 420.1		INTERVAL BETWEEN ONSET AND DEATH 10 Stands
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 9-2-60		
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.) none
20c. TIME OF INJURY Hour a.m. p.m. none	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.) none
20f. CITY, TOWN, OR LOCATION none		COUNTY STATE
21. I attended the deceased from 9-2-60 to 9-2-60 and last saw her/him alive on none . Death occurred at about 5:18 PM on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) Frazier D. Alexander MD	22b. ADDRESS 826 N CHANNING	22c. DATE SIGNED 9-3-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9/8/60	23c. NAME OF CEMETERY OR CREMATORY Washington Park
23d. LOCATION (City, town, or county) St. Louis County Mo		(State)

24. FUNERAL DIRECTOR Boyd Bros	ADDRESS 3706 Finney Ave	25. DATE RECD. BY LOCAL REG. SEP 6 1960	26. REGISTRAR'S SIGNATURE Loard Smith. M.D.
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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 Henry C. Williams

Licensed Embalmer No. 4781

P. O. Address 1205 Wals

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