

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO.		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Missouri		Length of stay in 1b		c. CITY OR TOWN St. Louis,	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp. #1		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 3930 Fairfax (If outside, give location)	
3. NAME OF DECEASED (Type or print) First Ernest Middle Diggs Last		4. DATE OF DEATH Month 12 Day 4 Year 60			

5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/>	Never Married <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH TO/14/1907	9. AGE (last birthday) 53	IF UNDER 1 YEAR	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY Packing Co.		11. BIRTHPLACE (City and state or country) LA.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Austin Diggs		13b. MOTHER'S MAIDEN NAME Martha Scott		14. NAME OF HUSBAND OR WIFE Bobella Diggs			

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. 47-24-9703	17. INFORMANT Wife	Address 3922 Fairfax
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia		INTERVAL BETWEEN ONSET AND DEATH 1 mo
DUE TO (b) Malignant hypertension		
DUE TO (c) 445x		

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from 10:12 to 10:22-60 and last saw her alive on 12-4-60
 Death occurred at 10:12 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE W. Yates Trotter J.M.D.	22b. ADDRESS 1515 Lafayette Ave.	22c. DATE SIGNED 12-4-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 12-10-1960	23c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
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24. FUNERAL DIRECTOR Katherine Williams P. Home	ADDRESS 1914 N. Sarah	25. DATE RECD. BY LOCAL REG. DEC 7 1960	26. REGISTRAR'S SIGNATOR Earl 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

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Melvin Blackman

Licensed Embalmer No. 396

P. O. Address 1221 N 9th

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