

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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=60-044698

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Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3383 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KOCH</u>		Length of stay in 1b <u>5 days</u>	c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1802 Cole</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>SAMUEL BOYD</u>			4. DATE OF DEATH Month Day Year <u>Nov. 14 1960</u>			
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5. SEX <u>M</u>	6. COLOR OR RACE <u>NEGRO</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/28/08</u>	9. AGE (last birthday) <u>52</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>OK OLONA, MISS.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>ISIAH BOYD</u>	13b. MOTHER'S MAIDEN NAME <u>EMMA WHITE</u>	14. NAME OF HUSBAND OR WIFE <u>EXIE JONES</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>497-07-6844</u>	17. INFORMANT Address <u>Hospital Record</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>COR PULMONALE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 2 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Chronic pulmonary tuberculosis, inactive</u>	<u>7 years</u>
	DUE TO (c) <u>Chronic pulmonary fibrosis + emphysema</u>	<u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic alcoholism</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.
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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 11/4/59 to 11/14/60 and last saw him alive on 11/14/60  
Death occurred at 10:20A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Ellis S. Sipins, M.D.</u>	22b. ADDRESS <u>Robert Koch Hospital</u>	22c. DATE SIGNED <u>11/16/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Anatomical</u>	23b. DATE <u>11-21-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical</u>	23d. LOCATION (City, town, or county) State <u>St. Louis, MO.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Sawland - Aked 4104 MARCHESTER</u>	25. DATE RECD. BY LOCAL REG. <u>11-21-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.