

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-010642
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2648

AMENDED
FILED MAR 30 1961

1. PLACE OF DEATH a. COUNTY				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>St. Louis Mo.</u>		Length of stay in 1b		c. CITY OR TOWN <u>St. Louis, Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1905 Carr St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle Last <u>Cushman</u>				4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>61</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-3-88</u>		9. AGE (last birthday) <u>72</u>		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) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) <u>Shaw Mississippi</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>Cisero Cushman</u>				13b. MOTHER'S MAIDEN NAME <u>Amy Jackson</u>				14. NAME OF HUSBAND OR WIFE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>Yes</u>				16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Chicago, Ill</u> <u>John S. Cushman 2323 S. State St.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Extensive Retro-Peritoneal Hemorrhage;</u> <u>Contrib. Fractured Pelvis; Subarachnoid Hemorrhage; suffered when struck by car operated by one Alvin Parson, at intersection of 21st & Market St., about 6:00 PM on March 15, 1961.</u> DUE TO (b) <u>accident</u> DUE TO (c) <u>accident</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown													
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) <u>see above</u>									
20c. INJURY OF Hour <u>6:00</u> a.m. p.m. Month, Day, Year <u>3-15-61</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. CITY, TOWN, OR LOCATION <u>St Louis, Mo</u>		COUNTY		STATE			
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____. Death occurred at _____ <u>10:19 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Paul J. Lemire</u> (Degree) <u>deputy coroner</u>				22b. ADDRESS <u>1300 Clark</u>				22c. DATE SIGNED <u>3/20/61</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>3-22-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		23d. LOCATION (City, town, or county) <u>Jefferson Barracks</u>		(State)					
24. FUNERAL DIRECTOR <u>A. L. Beal Und. Co. 4303 Delmar</u>				25. DATE RECD. BY LOCAL REG. <u>MAR 20 1961</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>							

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 3

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.