SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4689 -61-019591 STATE FILE NUMBER

FILED JUN 2 1961

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 St. Louis, Missouri
Length of stay in 1b

c. CITY OR TOWN St. Louis - 12
Inside Limits Yes ☑ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital
Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 914 Goodfellow Blvd
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: David Middle: Allen Last: Washington

4. DATE OF DEATH Month 4 Day 24 Year 61

5. SEX Male

6. COLOR OR RACE Negro

7. Married ☐ Never Married ☑ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 4-24-61

9. AGE (last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours 2 Min. 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Turner Graham Washington

13b. MOTHER'S MAIDEN NAME Julieanne Rambeau

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Julieanne Washington, 914 Goodfellow Address St. Louis - 12

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Prematurity

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Incompetent cervix

DUE TO (c) 761.5

INTERVAL BETWEEN ONSET AND DEATH

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 4-24-61, to 4-24-61 and last saw her/him alive on 4-24-61

Death occurred at 10:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Marvin Kennard (Degree or title) MD

22b. ADDRESS 4652 Neenland

22c. DATE SIGNED 5/9/61

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE MAY 31 1961

23c. NAME OF CEMETERY OR CREMATORY Anatomical Board

23d. LOCATION (City, town, or county) St. Louis, Mo. (State)

24. FUNERAL DIRECTOR Rowland Mortuary Svc. ADDRESS 4104-06 Manchester

25. DATE RECD. BY LOCAL REG. MAY 18 1961

26. REGISTRAR'S SIGNATURE Noel Smith, M.D.

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | 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 me, or by _____, Student Embalmer No._____ working under my personal supervision.

Student_____ Signed_____
Signature of Student Embalmer

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.