OURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10043 61-039285 STATE FILE NUMBER

FILED NOV 8 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.
Length of stay in 1b: 1 Yrs 23 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Chronic Hosp.
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo.
b. COUNTY
c. CITY OR TOWN St. Louis,
Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 4049 Finney
Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First Hezikah; Middle; Last Sykes
4. DATE OF DEATH: Month October; Day 28; Year 1961
5. SEX: Male
6. COLOR OR RACE: Col.
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH: 9-15-1900
9. AGE (last birthday): 61 yrs
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): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): Arkansas.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Bill Sykes
13b. MOTHER'S MAIDEN NAME: Laura Sykes
14. NAME OF HUSBAND OR WIFE: —
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
INFORMANT: Laura Johnson Address: 2905 Easton

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) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis — years
DUE TO (c) 420.0
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 10/5/60, to 10/28/61 and last saw her/him alive on 10/28/61
Death occurred at 2:25 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) George M. Janka, M.D.
22b. ADDRESS 5600 Arsenal
22c. DATE SIGNED 10/30/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 11-4-61
23c. NAME OF CEMETERY OR CREMATORY Greenwood Cem.
23d. LOCATION (City, town, or county) St. Louis Co. (State) Mo.
24. FUNERAL DIRECTOR Manuel F. Home — ADDRESS 1711 N. Taylor
25. DATE RECD. BY LOCAL REG. OCT 30 1961
26. REGISTRAR'S SIGNATURE Joan Smith, M.D.

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 m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Edward A. Flynn

Signature of Student Embalmer

Licensed Embalmer No. 4444

P. O. Address St Louis

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