

OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046287

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

12352

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		Length of stay in 1b 2 Days	c. CITY OR TOWN East St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4013 Baker Avenue		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Mattie B. Flakes			4. DATE OF DEATH Month Day Year December 30, 1961		
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/1/25	9. AGE (last birthday) 36	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Marianna, Arkansas	12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME WILLIE ALBERT WALKER		13b. MOTHER'S MAIDEN NAME LOTTIE BREWER		14. NAME OF HUSBAND OR WIFE JAKE FLAKES	
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. Unknown	17. INFORMANT Address E. St. Louis, Ill Merdice Russell, 4013 Baker Avenue,		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Aneurysm of cerebral artery DUE TO (c) 330X 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					INTERVAL BETWEEN ONSET AND DEATH 1 hr. Congenital
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.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
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
21. I attended the deceased from 12/28/61 to 12/30/61 and last saw her him alive on 12/30/61 Death occurred at 3:30 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) F. R. Bradley, M.D.			22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 12/31/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/7/62	23c. NAME OF CEMETERY OR CREMATORY Sunset Gardens of Memory		23d. LOCATION (City, town, or county) Stockey Township, Illinois	
24. FUNERAL DIRECTOR Address 2114 Missouri Avenue East St. Louis, Illinois		25. DATE RECD. BY LOCAL REG. JAN 2 1962	26. REGISTRAR'S SIGNATURE Road Smith, M.D.		

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Frank Prokop

Licensed Embalmer No. 4356

P. O. Address St. Louis, Mo.

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.