URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

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FILED VS JAN 2 9 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's 2 477 STATE FILE NUMBER

ENDED

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

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Enroute City Hospital | Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri. b. COUNTY

c. CITY OR TOWN: St. Louis. | Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location): 2912 No. Newstead | Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Russell; Middle; Last Alexander

4. DATE OF DEATH: Month January; Day 13; Year 1960

5. SEX: Male

6. COLOR OR RACE: Colored

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 8/22/1901

9. AGE (last birthday): 58 | 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): Custodian

10b. KIND OF BUSINESS OR INDUSTRY: Barber Shop

11. BIRTHPLACE (City and state or country): California, Missouri.

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

13a. FATHER'S NAME: Harvey Alexander

13b. MOTHER'S MAIDEN NAME: Maggie Kitchen

14. NAME OF HUSBAND OR WIFE: Emma

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

16. SOCIAL SECURITY NO.: 490-12-7991

17. INFORMANT Address: Gertrude Gathright, 5383 Northland, Ave.

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): Pneumonia

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

DUE TO (b):

DUE TO (c): 493 K

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 _____ to _____ and last saw her/him alive on _____

Death occurred at 1006A m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Patrick E. Taylor, Coroner

22b. ADDRESS: 1300 Clark Ave.

22c. DATE SIGNED: 1-14-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 1-16-60

23c. NAME OF CEMETERY OR CREMATORY: City Cemetery

23d. LOCATION (City, town, or county) (State): California, Mo.

24. FUNERAL DIRECTOR ADDRESS: Bowlin Funeral Home, California, Mo.

25. DATE RECD. BY LOCAL REG.: JAN 14 1960

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF

DOCUMENT

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 co 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.