

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36155

State File No.

FILED NOV 13 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9534**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY OR TOWN ST. LOUIS		a. STATE Missouri	b. COUNTY Jefferson
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) Arnold 1500	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If rural, give location) /	

3. NAME OF DECEASED (Type or Print)	a. (First) DONA	b. (Middle) ANNA	c. (Last) BEAN	4. DATE OF DEATH (Month) (Day) (Year)
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Nov. 8, 1879	9. AGE (In years last birthday) 72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and State or Foreign Country) Mokane, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Giles Callicott	13b. MOTHER'S MAIDEN NAME Unknown Calvin	14. NAME OF HUSBAND OR WIFE Thomas
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. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Henry Bean, 2827 Abner Pl.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CORONARY THROMBOSIS		II. OTHER SIGNIFICANT CONDITIONS		
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES		
		DUE TO (b) INTESTINAL OBSTRUCTION (? CAUSE)		
		DUE TO (c)		
		Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 5705

22. I hereby certify that I attended the deceased from **4:00pm 10-13 52**, to **10-13**, 1952, that I last saw the deceased alive on **10-13**, 1952, and that death occurred at **10:25pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) JR Bradley MD	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 10-14-52
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10-14-52	24c. NAME OF CEMETERY OR CREMATORY Mokane, Mo.
24d. LOCATION (City, town, or county) (State)		

DATE REC'D BY LOCAL REG. OCT 15 1952	REGISTRAR'S SIGNATURE J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4800 Washington Blvd
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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
Student Embalmer

Signed

John S. Kennedy
Licensed Embalmer No. 4194
P. O. Address St. Louis

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 this body is not embalmed, fact should be so stated above.