

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38863

State File No.

318

PRIMARY REG. DIST. NO. 1003 Registrar's No. 9710

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. 9710	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Washington</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>5 days</u>		c. CITY OR TOWN <u>Rural</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Baptist Hosp.</u>				e. STREET ADDRESS (If rural, give location) <u>near Paton 11001</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Margaret</u>			b. (Middle) _____		c. (Last) <u>Hedue</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 24-1954</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>March 29 1939</u>		9. AGE (In years last birthday) <u>15</u>	if UNDER 1 YEAR Months <u>6</u> Days <u>25</u>	if UNDER 1 HR. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Washington Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Robert Hedue</u>			13b. MOTHER'S MAIDEN NAME <u>Olivia Mason</u>		14. NAME OF HUSBAND OR WIFE _____		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, and for how long) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Olivia Hedue Paton Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute monocytic leukemia</u> ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____ Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>
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) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>2042</u>					
22. I hereby certify that I attended the deceased from <u>18 Oct. 1954</u> , to <u>24 Oct. 1954</u> , that I last saw the deceased alive on <u>23 Oct. 1954</u> , and that death occurred at <u>10 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Richard G. Jones MD</u>				(Degree or title)		23b. ADDRESS <u>3720 Washington</u>	23c. DATE SIGNED <u>25 Oct. 54</u>
24a. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>10-27-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Sunset Hill Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Washington Co. Mo.</u>		
DATE REC'D BY LOCAL REG. <u>OCT 26 1954</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Mrs. Luther Spahr Paton Mo</u>			

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.....
Signature of Student Embalmer

Signed *Murphy Spahr*.....

Licensed Embalmer No. *423*

P. O. Address *1st River*

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.