

STANDARD CERTIFICATE OF DEATH

23650
6598

FILED AUG 15 1955

State File No.
Registrar's No.

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Res. 5564 Chamberlain		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED a. (First) Jeannette		b. (Middle) Higdon	
c. (Last) Degge		4. DATE OF DEATH July 30, 1955	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Aug. 26, 1871
9. AGE (In years last birthday) 83yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	11. BIRTHPLACE (City and State or Foreign Country) St. Louis
10b. KIND OF BUSINESS OR INDUSTRY Home		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Middleton D. Degge		13b. MOTHER'S MAIDEN NAME Eugenia Ann Higdon	
14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Miss Ethel Degge 5564 Chamberlain	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heat Prostration ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Anemia DUE TO (c) Chronic Asthma II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 241XF	
20. INTERVAL BETWEEN ONSET AND DEATH		21. ALTERED? YES <input checked="" type="checkbox"/> NO <input 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?	
22. I hereby certify that I attended the deceased from Apr. 23, 1954, to July 30, 1955, that I last saw the deceased alive on July 30, 1955, and that death occurred at 2:30 P.M., from the causes and on the date stated above.			
23a. SIGNATURE H.A. Lehman MD		23b. ADDRESS 4362 Wainwright Ave	
23c. DATE SIGNED 7/30/55		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE Aug. 1, 1955		24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Alexander + Sons 6125 Delmar	
DATE REC'D BY LOCAL REG. AUG 1 1955		REGISTRAR'S SIGNATURE Carl Smith MD	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. W. H. Meyer Sr.
#73 Bellevue Acres

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 *Joe E. McCulloch*

Licensed Embalmer No. *246*

P. O. Address *6175 D*

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.