

FILED NOV 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39107**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **541** Registrar's No. **2527**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clayton		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Ferguson 12 9	
c. LENGTH OF STAY (In this place) DOA		d. STREET ADDRESS (If rural, give location) 7517 Halpin	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Louis Co., Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) BARBARA	b. (Middle) GRACE	c. (Last) DRAKE	4. DATE OF DEATH (Month) (Day) (Year) Oct. 30, 1955
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH July 10-1944	9. AGE (In years last birthday) 11	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Arthur L. Drake	13b. MOTHER'S MAIDEN NAME Eunice Taylor	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME A. L. Drake,	ADDRESS 7517 Halpin
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Unknown natural causes		INTERVAL BETWEEN ONSET AND DEATH Unknown
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	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 1955	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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) m.	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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Herbert R. Donke, M.D., Local Registrar	23b. ADDRESS 651 S. Brentwood Blvd.	23c. DATE SIGNED 11-14-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-1-55	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) Normandy, Missouri
DATE REC'D BY LOCAL REG. 11-1-55	REGISTRAR'S SIGNATURE Herbert R. Donke	25. FUNERAL DIRECTOR'S SIGNATURE WHITE CHAPEL, FERGUSON, MISSOURI	

(Licensed Embalmer's Statement on Reverse Side)

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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address Jennings, Missouri

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.