

Health, Welfare, Public Service

FILED JAN 29 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 3020
322

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

300
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR Yes <input type="checkbox"/> No <input type="checkbox"/> TOWN St. Louis		c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb HOSPITAL OR INSTITUTE 6111 Southwest Ave. 9		STREET ADDRESS 6111 Southwest Ave. 9 (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MADGE A. RAY			4. DATE OF DEATH Month Day Year Jan. 10 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1894
9. AGE (In years last birthday) 62		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (Retired) Toastwell Co.		10b. KIND OF BUSINESS OR INDUSTRY Toastwell Co.	11. BIRTHPLACE (City and state or country) Illinois
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Harry Treaster	
14. MOTHER'S MAIDEN NAME Mae Morris		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No None	
16. SOCIAL SECURITY NO.		17. INFORMANT Address St. Ann, Mo. Helen M. Holecheck 2957 Adie Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) V. D. Chronic Cardiac; Neutral Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Stenosis & Regurgitation, Tricuspid DUE TO (c) Rheumatic Fever Regurg. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 Mich 10 1956 Jan 10 57 and last saw her alive on 4/10/57 Death occurred at 12:45 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE W. H. Omsick MD (Physician or title)		22b. ADDRESS 3720 Washington Blvd.	
22c. DATE SIGNED 1/11/57		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Jan. 12, 1957	
23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		23d. LOCATION (City, town, or county) St. Louis Co. Mo.	
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway		25. DATE RECD. BY LOCAL REG. JAN 11 '57	
26. REGISTAR'S SIGNATURE Carl Smith MD			

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 *William B. White*

Licensed Embalmer No. *42*

P. O. Address *4220 1/2 St. N.W.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.