

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 15 1957

State File No. **10880**
Registrar's No. **2926**

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|---|--|--|---|--|--|--|--|
| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | Registrar's No. 2926 | |
| 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, write RURAL and give township) OR TOWN St. Louis | | c. LENGTH OF STAY (In this place) 10 days | | c. CITY OR TOWN St. Louis | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital | | | | e. STREET ADDRESS (If rural, give location) 4503 McPherson Ave. | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Mabel | | b. (Middle) B. | | c. (Last) Pickrel | | 4. DATE OF DEATH (Month) (Day) (Year) 3 23 57 | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Divorced 3 | | 8. DATE OF BIRTH Nov. 25, 1880 | |
| 9. AGE (In years last birthday) 76 | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 1 HRS. Hours _____ Min. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | | 11. BIRTHPLACE (City and State or Foreign Country) Mercer Co., Ill. / | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13a. FATHER'S NAME William Bowden | | | 13b. MOTHER'S MAIDEN NAME Laura Virginia Hyatt | | | 14. NAME OF HUSBAND OR WIFE Ray E. Pickrell | |
| 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 Ray E. Pickrel, 7830 Delmar Blvd. | | | |
| 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, ashenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ch. Cor Pulmonale ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pulmonary fibrosis DUE TO (c) Arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | INTERVAL BETWEEN ONSET AND DEATH 3 mo Many years | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION 241X | | | | 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 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 Feb 1957 to Mar 25, 1957 that I last saw the deceased alive on Mar 23, 1957 and that death occurred at 8:15 P.M. , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE Debra J. Pickrel (Degree or title) S.P. | | | | 23b. ADDRESS 8505 Delmar Blvd. | | 23c. DATE SIGNED 3-25-57 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) removal | | 24b. DATE 3/27/57 | | 24c. NAME OF CEMETERY OR CREMATORY St. Pauls Churchyard | | 24d. LOCATION (City, town, or county) (State) St. Louis County Mo. | |
| DATE REC'D BY LOCAL REG. MAR 26 '57 | | REGISTRAR'S SIGNATURE J. Earl Smith M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE Drehmann-Harral | | ADDRESS 1905 Union | |

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

Dr. DeLevan Calkins

Will come in about 10:00 AM

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..... *Albert P. Thompson*

Licensed Embalmer No. *4237*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.