

FILED MAR 29 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11681

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 693Health,
Welfare
Public
Service

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Affton</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Affton 4800</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>9630 Gravois</u>		Length of stay in lb <u>19 years</u>	d. STREET ADDRESS <u>9630 Gravois</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Reader</u> Last <u>Reader</u>			4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1957</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 7, 1876</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Shipman, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Oliver Reader</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Booth</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Thad Berkshire 9630 Gravois</u>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>10 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Althma</u>		
	DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			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 <u> </u> 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 <u>March 7</u> to <u>March 11</u> and last saw her/him alive on <u>3/11/57</u> Death occurred at <u>4:00p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
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22a. SIGNATURE <u>Walter L. O'Sullivan MD</u> (Degree or title)		22b. ADDRESS <u>9915 Gravois Rd</u>		22c. DATE SIGNED <u>Mar 13/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>3/14/1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Town Cemetery</u>	
			23d. LOCATION (City, town, or county) <u>Shipman Ill.</u>		(State)

24. FUNERAL DIRECTOR <u>J L Ziegenhein & Sons</u> ADDRESS <u>7027 Gravois</u>		25. DATE RECD. BY LOCAL REG. <u>3/13/57</u>		26. REGISTRAR'S SIGNATURE <u>Herbert B. Romelme</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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securing the medical certification in the specific manner required by the laws of Missouri.
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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APR 4 1963

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 E. P. Kidwell
Licensed Embalmer No. 387

P. O. Address 7027 Gray

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.