

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14429

STATE FILE NUMBER

FILED MAY 6 - 1957

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3787**

Health, Welfare Public Service

300 0  
1-56

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

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>JEFFERSON</b>                 |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |                                  | c. CITY OR TOWN <b>CRYSTAL CITY</b> <b>0501</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                            |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>04 INSTITUTION BARNES HOSPITAL</b> Length of stay in lb   |                                  | d. STREET ADDRESS (If outside, give location) <b>29 316 ENGLAND, AVE.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>NORA ALICE AXLEY</b>   |                                  |  | 4. DATE OF DEATH Month Day Year<br><b>APRIL 17, 1957</b>   |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>     | 8. DATE OF BIRTH<br><b>AUG. 29, 1887</b>   |
| 9. AGE (In years last birthday) <b>69</b>  |                                  | 10. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  | 11. BIRTHPLACE (City and state or country) <b>MONROE COUNTY, ILL.</b>                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSE WORK</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>JAMES HEATHERLY</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>LUCINDA DOBBINS</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.  | 17. INFORMANT Address<br><b>Eugene Axley St Louis, Mo.</b>   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>CARCINOMA OF CERVIX</b> |                                  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b> |
| 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.)<br><b>420.0H</b>  |  |
| 20c. TIME OF INJURY Hour Month, Day, Year<br>a. m. p. m.   |                                  | 20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                                  | 20f. CITY, TOWN, OR LOCATION COUNTY STATE  |  |
| 21. I attended the deceased from <b>1954</b> to <b>APRIL 17, 1957</b> and last saw her alive on <b>Apr. 17, 1957</b><br>Death occurred at <b>1:45 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.  |                                  |  |  |
| 22a. SIGNATURE (Degree or title)<br><b>E. J. Vermillion, M. D.</b>   |                                  | 22b. ADDRESS<br><b>BARNES HOSPITAL</b>   |  |
| 22c. DATE SIGNED<br><b>4/17/57</b>   |                                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE<br><b>4-20-57</b>      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GAMEL CEMETERY</b>  | 23d. LOCATION (City, town, or county) (State)<br><b>FESTUS, MISSOURI</b>                                   |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Andrew R. Polite Crystal City, Mo.</b>  |                                  | 25. DATE RECD. BY LOCAL REG.<br><b>APR 22 '57</b>  | 26. REGISTRAR'S SIGNATURE<br><b>Carl Smith Mo</b>  |

(Licensed Embalmer's Statement on Reverse Side)

**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 *Quincy R. Pelitte*  
Licensed Embalmer No. *348*

P. O. Address *Crystal City*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (6)  
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.