

FILED MAY - 8 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14560  
STATE FILE NUMBER  
4042

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

300  
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 a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS,			Inside Limits Year <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST LOUIS,		Inside Limits Year <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION JEWISH HOSPITAL			Length of stay in 1b	d. STREET ADDRESS 4929 CLAXTON AVE		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MAE C. CLINES				4. DATE OF DEATH Month Day Year APRIL 27, 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 26, 1905		9. AGE (In years last birthday) 51	IF UNDER 1 YEAR Months Days 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	11. BIRTHPLACE (City and state or country) ST LOUIS MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME BERNARD BERNS				14. MOTHER'S MAIDEN NAME MARY HOFFSCHELLE			
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 Address JAMES CLINES 4929 CLAXTON AVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ch. Valvular Heart Disease</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Arteriosclerosis</i> DUE TO (c) <i>Hypertension</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <i>4214</i>							INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i> <i>5 yrs.</i>
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 <i>March 4</i> to <i>April 27</i> and last saw <del>him</del> <i>him</i> alive on <i>4/26/57</i> Death occurred at <i>4:35 A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22. SIGNATURE (Printer's title) <i>J. Francis Muder</i>				22b. ADDRESS <i>4114 W Florissant</i>		22c. DATE SIGNED <i>4/27/57</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>4/30/57</i>	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		23d. LOCATION (City, town, or county) (State) ST LOUIS MISSOURI		
24. FUNERAL DIRECTOR ADDRESS STROOT - CARROLL 4600 NATUEAL BRIDGE AVE				25. DATE RECD. BY LOCAL REG. APR 29 '57		26. REGISTRAR'S SIGNATURE <i>Carl Smith MO</i>	

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 *M W Rueter*

Licensed Embalmer No. *48*

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.