

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15179

FILED APR 22 1957

Registration District No.

318

Primary Registration District No.

1003

STATE FILE NUMBER

3269

Health,
& Welfare
Public
Service

S. 300
V. 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 casually 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 b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN
ST. LOUIS, MO.			Yes <input type="checkbox"/> No <input type="checkbox"/>		Tegucigalpa
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b		STREET ADDRESS (If outside, give location)	
04 BARNES HOSPITAL		21hrs.		33	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First RAFAEL Middle MEDINA Last MEDINA RAUDALES			Month APRIL Day 3 Year 1957		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min.
Male <input type="checkbox"/> Female <input type="checkbox"/>	White	Unknown	Jan. 19, 1887	70	2 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)	
Attorney				Danli, Rep. of Honduras	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Rafael Medina Lainez			Mercedes Raudales		
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	
no		none		Judith Ordonez 418 Olive St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					INTERVAL BETWEEN ONSET AND DEATH
MYOCARDIAL INFARCTION					12 HRS.
DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE					MANY YRS.
DUE TO (c) GLAUCOMA					
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 checked="" type="checkbox"/> NO <input type="checkbox"/>
					420.0
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 <u>APRIL 2, 1957</u> , to <u>APRIL 3, 1957</u> and last saw her alive on <u>APRIL 3, 1957</u> Death occurred at <u>8:45 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title)			22b. ADDRESS		22c. DATE SIGNED
<i>E. D. Mellian, M. D.</i>			BARNES HOSPITAL		4/4/57
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
removal		4-5-57	Tegucigalpa Cemetery		Republic of Honduras
24. FUNERAL DIRECTOR ADDRESS			25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE	
C.R. Lupton & Sons 7233 Delmar Blvd.			APR 4 '57	<i>J. Carl Smith M.D.</i>	

(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 Arnold W. Schoene

Licensed Embalmer No. 3867

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.