

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15482

State File No. \_\_\_\_\_

FILED MAY - 8 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3894

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Mo.</i> b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>St. Louis</i>		c. LENGTH OF STAY (in this place) <i>14 yrs.</i>	c. CITY OR TOWN <i>St. Louis</i>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>St. Louis Chronic Hosp.</i>			e. STREET ADDRESS (If rural, give location) <i>211 2014 Division St.</i>		
3. NAME OF DECEASED (Type or Print) a. (First) <i>Mamie</i> b. (Middle) <i>Witherspoon</i> c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <i>4 15 1957</i>		
5. SEX <i>female</i>	6. COLOR OR RACE <i>col.</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>widow</i>	8. DATE OF BIRTH <i>1870</i>		9. AGE (In years last birthday) <i>87</i> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <i>Tennessee</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13a. FATHER'S NAME <i>unk.</i>		13b. MOTHER'S MAIDEN NAME <i>unk.</i>		14. NAME OF HUSBAND OR WIFE <i>unk.</i>	
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. <i>-</i>	17. INFORMANT'S SIGNATURE OR NAME <i>Hospital Records</i>		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
<p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Arteriosclerotic Heart Disease</i>			<i>15 yrs.</i>
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
		DUE TO (b) <i>Generalized arteriosclerosis</i>			<i>15 yrs.</i>
		DUE TO (c) <i>420.0</i>			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Aortic aneurysm</i>			<i>?15 yrs.</i>

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)		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 *6-23-42*, 19\_\_\_\_, to *4-15-57*, 19\_\_\_\_, that I last saw the deceased alive on *4-15-57*, 19\_\_\_\_, and that death occurred at *10:05am.*, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>John W. Beckham, M.D.</i>		23b. ADDRESS <i>5800 Arsenal St.</i>		23c. DATE SIGNED <i>4/16/57</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <i>4-30-57</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Anatomical Board</i>		24d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>	

DATE REC'D BY LOCAL REG. <i>APR 24 '57</i>	REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <i>Rowland-Aker Mortuary Service</i> 4104 Manchester Ave. St. Louis 10, Mo.		
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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.....

Licensed Embalmer No.....

P. O. Address.....

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.