

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19138

FILED MAY 20 1957

STATE FILE NUMBER

4251

Registration District No. **318** Primary Registration District No. **1003** Registrar No. **100**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <b>ST. LOUIS, MO.</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kirkwood</b> Inside Limits <b>4673</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb <b>04</b> HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) Reside on Farm <b>27</b> <b>1008 Ormond Drive</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>MAUDE</b> Middle <b>BELLE</b> Last <b>ORMSBY</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>3</b> Year <b>1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1891</b>	9. AGE (In years last birthday) <b>65</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Missouri.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	

13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No Nil</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT Address <b>Jean Lane, 1008 Ormond Drive, Kirkwood, Mo.</b>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			INTERVAL BETWEEN ONSET AND DEATH <b>MANY YRS.</b>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL ARTERIOSCLEROSIS</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>334x</b>			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.) <b>334x</b>		
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 **APRIL 23, 1957** to **MAY 3, 1957** and last saw her alive on **MAY 3, 1957**  
Death occurred at **8:15 P.M.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>C. D. Vamillion, M.D.</b>	22b. ADDRESS <b>M. D. BARNES HOSPITAL</b>	22c. DATE SIGNED <b>5/4/57</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>5-4-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>	23d. LOCATION (City, town, or county) (State) <b>Rolla, Missouri.</b>
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24. FUNERAL DIRECTOR <b>Albert H. Hoppe, 4700 Washington Blvd.,</b>	25. DATE RECD. BY LOCAL REG. <b>MAY 4 '57</b>	26. REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be causally related.

Health, Welfare, Public Service

300 -56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be entered.

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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 John S. Deane

Licensed Embalmer No. 41

P. O. Address St. La

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