

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19163**
Registrar's No. **4399**

FILED MAY 24 1957

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

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, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (in this place) 1 Mo. 7 days		c. CITY OR TOWN St. Louis,	
d. FULL NAME OF HOSPITAL OR INSTITUTION 26 St. Louis Chronic Hospital.		e. STREET ADDRESS (If rural, give location) 750 5700 Bartmer			
3. NAME OF DECEASED (Type or Print) a. (First) Juliet		b. (Middle)		c. (Last) Pfaff	
4. DATE OF DEATH (Month) (Day) (Year) May 5 1957		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH June 12, 1870		9. AGE (In years last birthday) 86	
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 Foreign Country) 0 Missouri,	
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Abram De Vault		13b. MOTHER'S MAIDEN NAME Medora Jones	
14. NAME OF HUSBAND OR WIFE —		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'S SIGNATURE OR NAME Hospital Records		ADDRESS			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) * This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 6 mo. ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 420.0			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? 2 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) (m.)		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 March 28, 1957, to May 5, 1957, that I last saw the deceased alive on May 5, 1957, and that death occurred at 2:00 P.M., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) John W. Beckham, M.D.		23b. ADDRESS 5800 Arsenal		23c. DATE SIGNED 5/6/57	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5-5-57		24c. NAME OF CEMETERY OR CREMATORY Jonesburg, Mo.	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington,			
DATE REC'D BY LOCAL REG. MAY 8 '57		REGISTRAR'S SIGNATURE Earl Smith M.D.		3. LICENSED EMBALMER'S STATEMENT ON REVERSE SIDE	

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..... *John S. Denueky*

Licensed Embalmer No. *916*

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.