

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

57-022520  
STATE FILE NUMBER  
5871

FILED JUL 5 1957

42593-57

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

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 Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
3. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LUKE'S HOSPITAL			Length of stay in lb	STREET ADDRESS 5510 CABANNE (If outside, give location)	
3. NAME OF DECEASED (Type or print) First DEBORAH Middle ROSE Last GEILE			4. DATE OF DEATH Month JUNE Day 20 Year 1957		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 18, 1957		9. AGE (In years last birthday) IF UNDER 1 YEAR: Months 2 Days Hours Min.
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) ST. LOUIS, MO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME LAWRENCE GEILE			14. MOTHER'S MAIDEN NAME ROSE McLAIN		
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 LAWRENCE GEILE, 5510 CABANNE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary atherosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Prematurity DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 2 days
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 762.5		20g. COUNTY STATE	
21. I attended the deceased from 6/18/57 to 6/20/57 and last saw her alive on 6/20/57 Death occurred at 1:40 PM m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Robert G. Holland M.D.			22b. ADDRESS 5535 Helman		22c. DATE SIGNED 6/20/57
23a. BURIAL, CREMATION, REMOVAL REMOVAL		23b. DATE JUNE 20, 1957		23c. NAME OF CEMETERY OR CREMATORY Catholic Cem.	
				23d. LOCATION (City, town, or county) (State) SILVER LAKE, MO.	
24. FUNERAL DIRECTOR Albert Bey, Perryville Mo.			25. DATE RECD. BY LOCAL REG. JUN 24 '57		26. REGISTRAR'S SIGNATURE Carl Smith Mo

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

(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.....

Licensed Embalmer No. 38

P. O. Address Ferrisville

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.