

HEALTH, Welfare, Public Service
 300
 -56
 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

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED JUL 26 1957

25888

STATE FILE NUMBER

318

1003

6345

Registration District No. Primary Registration District No. 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 checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital			Length of stay in 1b		d. STREET ADDRESS 5075a Delmar (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First John Middle Barter Last Acree				4. DATE OF DEATH Month July Day 7 Year 1957					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 17, 1896		9. AGE (In years last birthday) 60 IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer			10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (City and state or country) Galveston, Texas		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME John B. Acree				14. MOTHER'S MAIDEN NAME Nettie Arnold					
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. 493-09-6215		17. INFORMANT Address Mrs. Helen Acree, 5075a Delmar				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease.							INTERVAL BETWEEN ONSET AND DEATH one year		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Arterio Sclerosis generalized type					years		
		DUE TO (c) 420.0H							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Metastatic Carcinoma of lung - Carcinoma of aortal sinus							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)						
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 July 3-1957 to July 7-1957 and last saw ^{her} him alive on July 7-1957 Death occurred at 11:05 am on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) H. G. Newman M. D.					22b. ADDRESS 3720 Washington		22c. DATE SIGNED 7-8-57		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 7-10-57		23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory		23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.			
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd.				25. DATE RECD. BY LOCAL REG. JUL 8 57		26. REGISTRAR'S SIGNATURE J. Carl Smith MD			

Place

X

Place

X

Place

Place

Place

Place

Place

Place

Place

Place

Place

X

Place

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was

by me, or by Student Embalmer No.

working under my personal supervision.

Student Signature of Student Embalmer

Signed *J. W. Wilkinson*

Licensed Embalmer No. *35*

P. O. Address *M. L. ...*

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.