Health, Welfare Public Service

300 1-56

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

FILED JUL 26 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

26344
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6399

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis Mo. Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 01 1400 S 18 Length of stay in 1b 223
d. STREET ADDRESS (If outside, give location) 1400 S. 18

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY
c. CITY OR TOWN St Louis Inside Limits Yes ☐ No ☐
d. STREET ADDRESS 1400 S. 18 Reside on Form Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Edward Middle Last McHeal
4. DATE OF DEATH Month 6 Day 20 Year 57
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH —
9. AGE (In years last birthday) 92 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY NK
11. BIRTHPLACE (City and state or country) Mo
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME NK
14. MOTHER'S MAIDEN NAME NK
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NK (If yes, give war or dates of service) NK
16. SOCIAL SECURITY NO. NK
17. INFORMANT Address R.E. Taylor Co 1300 Clark

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility; INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized Arterio
DUE TO (c) Sclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hyp = 1
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 450.0
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) James M Kelly Deputy Coroner
22b. ADDRESS 1300 Clark
22c. DATE SIGNED 7-3-57

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE 7-31-57
23c. NAME OF CEMETERY OR CREMATORY Anatomical Board
23d. LOCATION (City, town, or county) (State) St Louis, Mo.

24. FUNERAL DIRECTOR ADDRESS Rowland-Aker Mortuary Service 4104 Manchester Ave. St. Louis 10, Mo.
25. DATE RECD. BY LOCAL REG. JUL 10 '57
26. REGISTRAR'S SIGNATURE Earl Smith MD MSB

(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 em

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. (F
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.