

Health, Welfare, Public Service
 300
 1-56
 All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27017
 STATE FILE NUMBER

FILED JUL 17 1957

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1618

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Moline</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Glasgow Village</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Halls Ferry Mem. Home</u>			Length of stay in lb <u>10</u>	d. STREET (If outside, give location) <u>MO. ADDRESS 140 Glen Garry Rd.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Helen</u> Last <u>Going</u>				4. DATE OF DEATH Month <u>June</u> Day <u>4th</u> , Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/21/1889</u>	9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>	11. BIRTHPLACE (City and state or country) <u>Edwardsville, Ill</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>August Graber</u>				14. MOTHER'S MAIDEN NAME <u>Mary Vogel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>	17. INFORMANT Address <u>Chester Going 140 Glen Garry Rd.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Heart disease</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left hemiplegia 3 years.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>unknown</u> <u>unknown</u>	
20a. ACCIDENT <input type="checkbox"/>	20b. SUICIDE <input type="checkbox"/>	20c. HOMICIDE <input type="checkbox"/>	20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20e. TIME OF INJURY Hour <u> </u> Month <u> </u> Day <u> </u> , Year <u> </u> a. m. <u> </u> p. m. <u> </u>							
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 <u>Sept 25, 1956</u> to <u>June 24, 1957</u> and last saw her <u>alive</u> on <u>June 17, 1957</u> Death occurred at <u>6:45 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Lewis Pittman MD</u>				22b. ADDRESS <u>8231 Clayton Rd (17)</u>		22c. DATE SIGNED <u>6/25/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>June 26th 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Normandy, Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Harry A. Kraeger 223 Crandon Dr.</u>			25. DATE RECD. BY LOCAL REG. <u>6-25-57</u>	26. REGISTRAR'S SIGNATURE <u>Herbert R. Danks MD</u>			

Clayton 24, Mo. (Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.....
Robert M. Murray
37498

Licensed Embalmer No.....

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.