

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED SEP 17 1957

State File No. **33993**  
Registrar's No. **8236**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		State File No. <b>33993</b>		Registrar's No. <b>8236</b>		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Washington</b>						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <b>Old Mines</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>				e. STREET ADDRESS <b>31 R.R. 119</b>						
3. NAME OF DECEASED (Type or Print) a. (First) <b>Mary</b> b. (Middle) <b>Lourds</b> c. (Last) <b>Politte</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 3 1957</b>							
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never married</b>	8. DATE OF BIRTH <b>Sept. 3 1957</b>		9. AGE (In years last birthday) <b>3</b>	UNDER 1 YEAR Months _____	1 YEAR Days _____	IF UNDER 2 HRS. Hours _____	Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				
13a. FATHER'S NAME <b>Willard F. Politte</b>			13b. MOTHER'S MAIDEN NAME <b>Rachel V. Politte</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Willard F. Politte</b> 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) <b>Prematurity - 20 weeks</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Reb. Mascon</b>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>776x</b>						INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? <b>2</b> 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) _____		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 <b>9/3</b> <b>1957</b> , to <b>9/3</b> <b>1957</b> , that I last saw the deceased alive on <b>9/3</b> <b>1957</b> , and that death occurred at <b>6:30</b> <b>a.m.</b> , from the causes and on the date stated above.										
23a. SIGNATURE <b>J. M. Rowden</b> (Degree or title) _____				23b. ADDRESS <b>4500 Olive St</b>			23c. DATE SIGNED <b>SEP 3 57</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>9-3-57</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Catholic Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Old Mines, Mo.</b>					
DATE REC'D BY LOCAL REG. <b>SEP 3 57</b>		REGISTRAR'S SIGNATURE <b>Carl Smith</b>			25. FUNERAL DIRECTOR'S SIGNATURE <b>Smith Funeral Home, Potosi, Mo.</b> ADDRESS _____					

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.....  
No Embalm  
Licensed Embalmer No. ....

P. O. Address .....

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.