

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37104

STATE FILE NUMBER 9407

FILED NOV 7 1957

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 Mo. 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 25 City Hospital		Length of stay in lb 1 week		d. STREET ADDRESS 2217 N. Thompson 3427 Washington		Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Ackerman Last Ackerman				4. DATE OF DEATH Month 10 Day 8 Year 57			
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 Nov. 28, 1879		9. AGE (In years last birthday) 77 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) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Atlantic City, N. J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jules Ackerman				14. MOTHER'S MAIDEN NAME Katherine unknown			
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 Address 8310 White Water Dr. Mrs. Florence Hughes			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tubercular meningitis; Fracture of Left Femur; Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) E904.0 DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 21						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT <input checked="" 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.) Slipped when she fell at home				
20c. TIME OF INJURY Hour . Month . Day . Year a. m. 9 29 57 p. m. September 29 1957			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, etc., office bldg., etc.) Home				
20e. CITY, TOWN, OR LOCATION St. Louis COUNTY STATE			20f. CITY, TOWN, OR LOCATION St. Louis COUNTY STATE				
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____. Death occurred at 1:50 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Death or title) James M. Reilly, Deputy ADDRESS 1300 Clark						22c. DATE SIGNED 10-9-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 10/11/57		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Mo.	
24. FUNERAL DIRECTOR ADDRESS Drehmann-Harral 1905 Union				25. DATE RECD. BY LOCAL REG. OCT 9 '57		26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. S.P.	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service
300-1-56
All diseases in Part I must be causally 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. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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 *Albert R Thompson*.....

Licensed Embalmer No. *42*.....

P. O. Address *St. John*.....

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.