

FILED NOV 15 1957

STANDARD CERTIFICATE OF DEATH

37992
STATE FILE NUMBER
10520

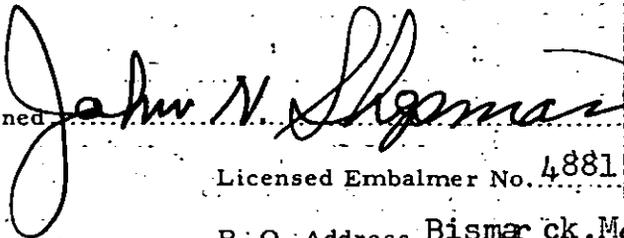
Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

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 type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 01 Home 7711 Virginia				Length of stay in 1b 4 Yrs.		d. STREET ADDRESS 7711 Virginia	
3. NAME OF DECEASED (Type or print) UNICE				First Middle Last S. POLITTE		4. DATE OF DEATH Nov. 4, 1957	
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 3-30-1906	
9. AGE (In years last birthday) 51		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Same		11. BIRTHPLACE (City and state or country) Wash. Co., Missouri	
10c. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Acan Politte		14. MOTHER'S MAIDEN NAME Leona Labruyere			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Lorraine Vuichard			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage		Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 3 days			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Stroke		331x			
DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 11-1-57 to 11-4-57 and last saw her alive on 11-2-57 Death occurred at 10:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE Owen J. McNamee M.D.		22b. ADDRESS 7619 Ivory St. Louis, Mo		22c. DATE SIGNED 11-4-57	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11-4-57		23c. NAME OF CEMETERY OR CREMATORY Masonic		23d. LOCATION (City, town, or county) (State) Blackwell, Missouri	
24. FUNERAL DIRECTOR Shipman & Sons		ADDRESS Bismarck, Mo.		25. DATE RECD. BY LOCAL REG. NOV 6 '57		26. REGISTRAR'S SIGNATURE E. Smith MO MJB	

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  _____

Licensed Embalmer No. 4881

P. O. Address Bismarck, M

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.