Health, Welfare Public Service

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1-56

FILED OCT 21 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38446
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2483

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton — Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION County Hospital — Length of stay in Ib 1 Week

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN Valley Park 4000 — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) Rt 2 — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Daniel Middle: NMI Last: Flemming
4. DATE OF DEATH Month: Oct. Day: 6 Year: 1957
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 7-25-1881
9. AGE (In years last birthday) 76 — 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) Caretaker
10b. KIND OF BUSINESS OR INDUSTRY Residential
11. BIRTHPLACE (City and state or country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Robert Flemming
14. MOTHER'S MAIDEN NAME Elizabeth Cressman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 497-20-3169
17. INFORMANT Mrs. C. W. Bowen, Address Rt. 1, Orchard Farm St. Charles Co., Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary embolus - (suspected)
Conditions, if any, which gave rise to above cause (a), stating the underlying cause, last.
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Post-op perforated duodenal ulcer 5411
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
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 10-1-57 to 10-6-57 and last saw him alive on 10-6-57
Death occurred at 5:15 Am on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE Albert M. Lay MD (Degree or title)
22b. ADDRESS 601 S. Brentwood, Clayton, Mo
22c. DATE SIGNED 10-7-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
23b. DATE 10-9-1957
23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory
23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR JAY B. SMITH, Maplewood, Mo. ADDRESS
25. DATE RECD. BY LOCAL REG. 10-8-57
26. REGISTRAR'S SIGNATURE Herbert B. Wemke MD

(Licensed Embalmer's Statement on Reverse Side)

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

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 H E Burgess

Licensed Embalmer No. 40

P. O. Address Maplew

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (E
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.