

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38577

FILED OCT 16 1957

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 546 Registrar's No. 2303

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <u>OVERLAND</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>OVERLAND 424X</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LACKLAND REST HOME</u> Length of stay in lb <u>4 YEARS</u>		d. STREET ADDRESS <u>2330 HUNTINGTON</u> (If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>MARTHA JANE WORLEY</u> First Middle Last			4. DATE OF DEATH <u>9-17-57</u> Month Day Year		
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>OCT 29 1869</u>	9. AGE (In years last birthday) <u>87</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and state or country) <u>HAYWOOD TENNESSEE</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES DAVID BEARDEN</u>			14. MOTHER'S MAIDEN NAME <u>MAREY ELIZABETH BRADLEY</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	17. INFORMANT <u>LEONA KEMMERT 2330 HUNTINGTON</u> Address		

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>Vaso-motor collapse</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hr.</u>
Conditions, if any, which gave rise to above cause, (a), stating the underlying cause last.	DUE TO (b) <u>Consequent Heart failure</u>	
	DUE TO (c) <u>Arteriosclerosis</u>	
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. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from 9/7/57 to 9/17/57 and last saw her him alive on 7/19/57  
Death occurred at 3:57 PM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE L. P. Williams, M.D. (Degree or title) 22b. ADDRESS 10426 Lackland Rd 22c. DATE SIGNED 9/7/57

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REBURIAL</u>	23b. DATE <u>9-18-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EDDINGTON-CEMETERY</u>	23d. LOCATION (City, town, or county) <u>PIEDMONT Cem.</u> (State) <u>MO</u>
24. FUNERAL DIRECTOR <u>EARL HILLEMANN</u> ADDRESS <u>OVERLAND MO</u>	25. DATE RECD. BY LOCAL REG. <u>9-18-57</u>	26. REGISTRAR'S SIGNATURE <u>Herbert B. Donke MD</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service  
 300  
 1-56  
 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 *Gust. Silliman*

Licensed Embalmer No. *3501*

P. O. Address *Orland 14*

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.