

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.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 27 1957

41727
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11075**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY					
--b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 5351 Delmar - St. Louis, Mo.		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 Masonic Home of Mo.			Length of stay in lb		d. STREET ADDRESS 5351 Delmar		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Margaret Middle R. Last Beadle				4. DATE OF DEATH Month 11 Day 18 Year 1957					
5. SEX F		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-16-1870		9. AGE (In years last birthday) 87	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Memphis, Tennessee		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Fox				14. MOTHER'S MAIDEN NAME Mary Kennedy					
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 Masonic Home of Missouri-5351 Delmar Blvd				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocarditis							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) Generalized Arterio Sclerosis		DUE TO (c)		20 yrs			
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"/> 2		
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 9 Month 10 Day 57 Year 57 a. m. 34 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 9-10-57 to 11-18-57 and last saw her/him alive on 11-18-57 . Death occurred at 9:34 am on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Harold E. Walters M.D.				22b. ADDRESS 3720 Washington St. Louis Mo			22c. DATE SIGNED 11-18-57		
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 11/20/57		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County Mo.			
24. FUNERAL DIRECTOR Drehmann-Harral			ADDRESS 1905 Union		25. DATE RECD. BY LOCAL REG. NOV 1957		26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.		

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 A. Thompson*

Licensed Embalmer No. *42*

P. O. Address *St. Louis*

**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.**