

FILED DEC 10 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41786**
Registrar's No. **11489**

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

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| 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, write RURAL and give town) St. Louis | | c. LENGTH OF STAY (in this place) 1 day | | c. CITY OR TOWN St. Louis | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital | | e. STREET ADDRESS (If rural, give location) 4515 Lindell Blvd. | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Amanda | | b. (Middle) S. | | c. (Last) Breeze | |
| 4. DATE OF DEATH Nov. 29th. 1957 | | 5. SEX F | | 6. COLOR OR RACE W | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed | | 8. DATE OF BIRTH 9-11-1880 | | 9. AGE (In years last birthday) 77 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home | | 10b. KIND OF BUSINESS OR INDUSTRY at home | | 11. BIRTHPLACE (City and State or Foreign Country) St. Louis Missouri | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13a. FATHER'S NAME Joseph Stehle | | 13b. MOTHER'S MAIDEN NAME Mary T. Archambault | |
| 14. NAME OF HUSBAND OR WIFE Clay Breeze (Deceased) | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. no | |
| 17. INFORMANT'S SIGNATURE OR NAME Viola Jaas | | ADDRESS 5927 Romaine | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio Sclerotic Heart Disease | | II. OTHER SIGNIFICANT CONDITIONS 420.0 | | MEDICAL CERTIFICATION | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from 11-29, 1957 , to 11-29, 1957 , that I last saw the deceased alive on 11-29, 1957 , and that death occurred at 11:45p m. , from the causes and on the date stated above. | | | | | |
| 23a. SIGNATURE (Degree or title) L. Hayden M.D. | | 23b. ADDRESS 4301 Holmeadow | | 23c. DATE SIGNED 11-30-57 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 24b. DATE 12-2-1957 | | 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | |
| 24d. LOCATION (City, town, or county) (State) St. Louis Missouri | | DATE REC'D BY LOCAL REG. DEC 2 57 | | REGISTRAR'S SIGNATURE Carl Smith | |
| 25. FUNERAL DIRECTOR'S SIGNATURE Walter J. Donnelly | | ADDRESS 3840 Lindell Blvd. | | | |

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

2286 (Licensed Embalmer's Statement on Reverse Side)

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 *Francis Williamson*.....

Licensed Embalmer No. *3565*

P. O. Address *3840 Lind*

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.