

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41894

STATE FILE NUMBER

FILED DEC 9 - 1957

Registration District No. **318** Primary Registration District No. **1003** Registrar **10741**

Health, & Welfare
S. Public
Hb Service

S. 300
v. 7-56

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN DeSt. Louis		c. CITY OR TOWN Normandy	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hosp.		d. STREET ADDRESS (If outside, give location) 7634 Lammert La.	
3. NAME OF DECEASED (Type or print) First Cora Middle Clara Last Dean		4. DATE OF DEATH Month Nov. Day 9 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 6, 1889
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) St. Louis, Mo.
13. FATHER'S NAME Emil F. Kuechler		14. MOTHER'S MAIDEN NAME Wilhelmina Wingardt	
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 Paul H. Dean, Normandy, Mo.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) my over-did ingestion coronary thrombosis 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) 4201			INTERVAL BETWEEN ONSET AND DEATH 4 days
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 5:33 / 11/9/57 to 11/9/57 and last saw her alive on 11/9/57 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (If three or (11g)) Frank T. Keely M.D.		22b. ADDRESS 40 N. Ferguson	22c. DATE SIGNED 11/10/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-12-57	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Ceml.	23d. LOCATION (City, town, or county) (State) Normandy, Mo.
24. FUNERAL DIRECTOR ADDRESS White Chapel, Ferguson, Mo.		25. DATE RECD. BY LOCAL REG. NOV 12 57	26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D.

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 *Eleana Province*.....

Licensed Embalmer No. *340*.....

P. O. Address *Jennings*.....

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.