

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

FILED NOV 21 1957

42709  
STATE FILE NUMBER  
10898  
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Hamilton Med.Center</b>		Length of stay in 1b <b>Life</b>	
3. NAME OF DECEASED (Type or print) <b>MARY</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>12,</b> Year <b>1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 1870</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>
13a. FATHER'S NAME <b>Allen (NMN) Trail</b>		13b. MOTHER'S MAIDEN NAME <b>Mary G. Wilson</b>	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Mr. W.W. Keyser, 5379 Pershing</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Coronary insufficiency</b>			<b>13 years</b>
DUE TO (c) <b>General arteriosclerosis</b>			<b>15 years +</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Decubiti massive - 3 months. Terminal hypostatic pneumonia 1 day</b>			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. 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 <b>Before 1944</b> to <b>11-12-57</b> and last saw her <sup>him</sup> alive on <b>11-12-57</b> Death occurred at <b>8:30</b> P. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>J. Andrew Clark</b> (Degree or title) <b>M.D.</b>		22b. ADDRESS <b>864 Hamilton Blvd St. Louis 12 Mo</b>	
22c. DATE SIGNED <b>11-14-57</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	
23b. DATE <b>Nov. 15, 1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine Cemetery</b>	
23d. LOCATION (City, town, or county) <b>St. Louis</b>		23e. (State) <b>Mo.</b>	
24. FUNERAL DIRECTOR <b>Alexander &amp; Sons, 6175 Delmar</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 14 57</b>	
26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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.

Dr J Fred Clark will call

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 jos. E. McCulloch

Licensed Embalmer No. 2420

P. O. Address 612 S. Delaware

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.