

Health
Welfare
Public
Service

300
7-56

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. All Director, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED FEB 18 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-007961

STATE FILE NUMBER

318

1003

986

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

| | | | | | |
|--|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Lemay 4870 | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 02 Alexian Brothers Hospital | | Length of stay in lb 9 Days | d. STREET ADDRESS 2112 Kevin | | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First James Middle A. Last White | | | 4. DATE OF DEATH Month January Day 26 Year 1958 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH August 24, 1902 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Awning Hanger | | 10b. KIND OF BUSINESS OR INDUSTRY Jefferson T. & A. Co. | | 11. BIRTHPLACE (City and state or country) Fairfield, Illinois | |
| 13. FATHER'S NAME Henry White | | | 14. MOTHER'S MAIDEN NAME Margaret Crews | | |
| 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. 494-09-1993 | | 17. INFORMANT Address Mrs. Myrtle White 2112 Kevin Lemay 23, 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) Acute myocardial infarction | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | 420.1 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Wenodermal ulcer | | | | | 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 _____ a. m. _____ p. m. Month, Day, Year _____ | | | | | |
| 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 Jan 17, 58 to Jan 24, 58 and last saw him alive on Jan 25, 58 Death occurred at 7:50 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <i>Ray C. Hoffmeister</i> | | | 22b. ADDRESS 7702 Irving Ave | | 22c. DATE SIGNED 1/27/58 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE Jan. 29, 1958 | 23c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery | | 23d. LOCATION (City, town, or county) (State) 1890 Lemay Ferry Rd., Lemay, Mo. |
| 24. FUNERAL DIRECTOR C. Hoffmeister Mortuaries 7814 S. Broadway | | 25. DATE RECD. BY LOCAL REG. JAN 27 '58 | | 26. REGISTRAR'S SIGNATURE <i>Carl Smith</i> mab | |

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 *Linus C. Hoffmeister*

Licensed Embalmer No. *38*

P. O. Address *7814 S. 12*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (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.