

FILED MAR 5 - 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-008189

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 545 Registrar's No. 422

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Maplewood</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Maplewood Nurs. Home</u>				Length of stay in lb <u>2 YRS, 6</u>		d. STREET ADDRESS (If outside, give location) <u>5850a Wabada</u>	
3. NAME OF DECEASED (Type or print) First <u>FRED</u> Middle <u>J.</u> Last <u>TEMPLE</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 3, 1871</u>		9. AGE (In years last birthday) <u>86</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barbering</u>		11. BIRTHPLACE (City and state or country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. J. A. Smith, 310 Chestnut</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pericious anemia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <u>290.0</u>						INTERVAL BETWEEN ONSET AND DEATH <u>over 3 yrs.</u>	
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"/> <u>2</u>	
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. _____							
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 <u>Jan 26, 1958</u> to <u>Feb 10, 1958</u> and last saw <u>her</u> alive on <u>Feb 10, 1958</u> Death occurred at <u>7:30 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>James B. Jones M.D.</u> (Degree or title)				22b. ADDRESS <u>337 W. Lockwood Webster Groves 19, Mo.</u>		22c. DATE SIGNED <u>2-11-58</u>	
23a. BURIAL/CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2-12-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>		23d. LOCATION (City, town, or county) <u>St. Louis, Co., Mo.</u> (State)		
24. FUNERAL DIRECTOR <u>Parker-Aldrich, Webster Groves</u> ADDRESS _____				25. DATE RECD. BY LOCAL REG. <u>2-11/58</u>		26. REGISTRAR'S SIGNATURE <u>Herbert R. Donke M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

Dr.

Use only black ink or ribbon typewrite if possible. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard diseases in Part I must be casually related.

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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. *Leslie Welch*.....

Licensed Embalmer No. *43*.....

P. O. Address *Wester*.....

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.