

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-023129

STATE FILE NUMBER

26791  
FILED JUN 27 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

5694

300

1-57

3

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>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
38 FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Paroute City Hospital</b>		Length of stay in lb <b>2 mo.</b>	d. STREET ADDRESS (If outside, give location) <b>1000 Chouteau Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Linda</b> Middle <b>Kay</b> Last <b>Blair</b>			4. DATE OF DEATH Month <b>May</b> Day <b>31</b> Year <b>1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</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>March 26, 1958</b>	9. AGE (In years last birthday) IF UNDER 1 YEAR: Months <b>2</b> Days <b>5</b> IF UNDER 24 HRS.: Hours <b>0</b> Min.	
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	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>James Blair</b>		13b. MOTHER'S MAIDEN NAME <b>Eva Smithardt</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
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>James Blair, 1000 Chouteau Ave.</b> 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) <b>Carbon Monoxide Poisoning</b>					INTERVAL BETWEEN ONSET AND DEATH
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) <b>Asphyxiated while sleeping of which deceased was sleeping in hands of mother in House at 1000 Chouteau about 5:23 am., May 31st 1958.</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" 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 for it only) <b>Asphyxiated while sleeping of which deceased was sleeping in hands of mother in House at 1000 Chouteau about 5:23 am., May 31st 1958.</b>			
20c. TIME OF INJURY Hour <b>5:23</b> Month, Day, Year <b>May 31st 1958</b>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>22nd Ave</b>			
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <b>St. Louis Mo</b>		COUNTY, STATE	
21. I attended the deceased from <b>530 A</b> to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>James M. Keely, Deputy Coroner</b>			22b. ADDRESS <b>1300 Clark</b>		22c. DATE SIGNED <b>6.2.58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>6-2-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
24. FUNERAL DIRECTOR <b>Albert H. Hoppe, 4700 Washington Blvd.</b>		ADDRESS		25. DATE RECD. BY LOCAL REG. <b>JUN 2 '58</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith MO</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 .....  
*Not Embalmed*  
*Lawrence G. Meyer*  
Licensed Embalmer No. ....  
P. O. Address .....

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.