

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-026745

STATE FILE NUMBER

7075

Health,  
& Welfare  
Public  
Service

300  
1-56

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

Registration District No. <b>318</b>		Primary Registration District No. <b>1003</b>		Registrar's No. <b>7075</b>	
1. PLACE OF DEATH a. COUNTY <b>St Louis Mo</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5131 Maple</b>		Length of stay in 1b <b>2 5/9</b>	STREET ADDRESS <b>5131 Maple</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Mary Lee Blanchard</b>			First <b>Mary</b>	Middle <b>Lee</b>	Last <b>Blanchard</b>
4. DATE OF DEATH <b>July 15 1958</b>		Month <b>July</b>	Day <b>15</b>	Year <b>1958</b>	
5. SEX <b>Female 3</b>	6. COLOR OR RACE <b>Col</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>27 August 1888</b>	9. AGE (In years last birthday) <b>69</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maid</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Aberdeen Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
13. FATHER'S NAME <b>Addison Clay</b>			14. MOTHER'S MAIDEN NAME <b>Dee Patton s</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>490-36-9668</b>	17. INFORMANT <b>Mrs Mary Hodge 5131 Maple</b> <b>Mrs Mare E. Dean</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>Inanition</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3mo.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinoma Right Maxillary Sinus</b>					<b>9yrs.</b>
DUE TO (c) <b>160.2</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <b>Arteriosclerotic Heart Disease</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
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 <b>Hour</b> a. m. <b>Month, Day, Year</b> 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>3-5-57</b> , to <b>7-15-58</b> and last saw <del>xxx</del> alive on <b>7-15-58</b> Death occurred at <b>4:55</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>J. Paul Smyth, M.D.</i>			22b. ADDRESS <b>4903a Easton St. Louis 13</b>		22c. DATE SIGNED <b>7-16-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>7/26/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	23d. LOCATION (City, town, or county) <b>St. Louis</b>	COUNTY <b>County</b>	STATE <b>Mo</b>
24. FUNERAL DIRECTOR <b>Herman J. Smith</b>		ADDRESS <b>4247/w Labadie</b>	25. DATE RECD. BY LOCAL REG. <b>JUL 17 58</b>	26. REGISTRAR'S SIGNATURE <i>J. Paul Smyth, M.D.</i>	

(Licensed Embalmer's Statement on Reverse Side)

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ..... Student Embalmer No.....

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *W. C. Anderson*.....

Licensed Embalmer No. *317*

P. O. Address *4575 1st St*

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.