

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-034185  
STATE FILE NUMBER

FILED OCT 3 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7942

S. 300  
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1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN East St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Inf.			Length of stay in lb 6 days		8. STREET ADDRESS (If outside, give location) 32 34-E John DeShields Homes		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Mabel Buchanan Falconer				4. DATE OF DEATH Month Day Year August 14, 1958					
5. SEX Female		6. COLOR OR RACE 3 Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Nov. 27, 1910		9. AGE (In years last birthday) 47	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Metropolis, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME Ra Buchanan			13b. MOTHER'S MAIDEN NAME Mattie Stalls			14. NAME OF HUSBAND OR WIFE Lester Falconer			
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. 327-22-2542		17. INFORMANT Address 34-E John DeShields Homes E. St. Louis				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anesthesia								ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cardiac Arrest								603 x F	
DUE TO (c)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) White deceased was being prepared for an autopsy at St. Mary's Infirmary on August 14, 1958									
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 (a) or (b).) Prepared for an autopsy at St. Mary's Infirmary on August 14, 1958						
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. 8 14 58			20d. INJURY OCCURRED WHILE AT <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.) 22nd St			20f. CITY, TOWN, OR LOCATION COUNTY STATE St Louis Mo						
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ 10:21 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) James M Kelly Deputy Clerk					22b. ADDRESS 1300 Clark			22c. DATE SIGNED 8-15-58	
23. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8/15/58		23c. NAME OF CEMETERY OR CREMATORY Sunset Garden of Memory			23d. LOCATION (City, town, or county) (State) Stokey Township, Illinois		
24. FUNERAL DIRECTOR Marrion's Office E. St. Louis, Ill.				ADDRESS 2114 Mo Ave		25. DATE RECD. BY LOCAL REG. AUG 15 '58		26. REGISTRAR'S SIGNATURE Carl Smith MD m83	

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related. Cause of death must be only standard nomenclature in item 18. No symptoms will be listed. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

Obstruction of water

MEDICAL CERTIFICATION

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 *Kenn Trovoff* .....

Licensed Embalmer No. *4356* .....

P. O. Address *St. Louis, Mo.* .....

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.