

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-034204

STATE FILE NUMBER
9370

FILED OCT 10 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

300
1-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		
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 St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hosp.		Length of stay in lb 4059	d. STREET ADDRESS (If outside, give location) 501 Clara		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last INA FLEISHEL			4. DATE OF DEATH Month Day Year Sept. 30, 1958		
5. SEX Female	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 Oct. 9, 1893	9. AGE (In years last birthday) 64	10. UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Dr. C. C. Morris		13b. MOTHER'S MAIDEN NAME Willa Raines		14. NAME OF HUSBAND OR WIFE J. Travis	
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. none	17. INFORMANT J. Travis Fleishel 501 Clara Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pneumonia - viral</i>					INTERVAL BETWEEN ONSET AND DEATH 2 wks
Conditions, if any, which gave rise to above cause (a), storing the underlying cause last. DUE TO (b) <i>Aspiration of saliva associated</i>					
DUE TO (c) <i>Cerebro vascular accident</i>					12 wks
PART II. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Post encephalitic residual</i>					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.) 331x		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>March 1958</i> to <i>death</i> and last saw her <i>alive</i> on <i>9/29/58</i> Death occurred at <i>LA.</i> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Charles T. Duden</i> (Degree or title) M.D.			22b. ADDRESS <i>3720 Washington Ave</i>		22c. DATE SIGNED <i>9-30-58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE <i>10-2-58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Bellefontaine Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis, Missouri</i>
24. FUNERAL DIRECTOR <i>C.R. Lupton and Sons 7233 Delmar</i>			25. DATE RECD. BY LOCAL REG. <i>SEP 30 58</i>		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith M.D.</i>

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 *Arnold W. Schoene*

Licensed Embalmer No. *3864*
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.