

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037571

STATE FILE NUMBER

FILED OCT 17 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9629

300
1-57

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri.</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		CITY OR TOWN <u>St. Louis,</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis Chronic Hospital 2 Yrs.</u>		Length of stay in lb <u>9 Mo.</u>		d. STREET ADDRESS <u>4454 Vista Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillian Austin</u>				4. DATE OF DEATH Month Day Year <u>October 5-1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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 30, 1887</u>		9. AGE (in years last birthday) <u>71</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>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Meyer</u>			13b. MOTHER'S MAIDEN NAME <u>Helen</u>			14. NAME OF HUSBAND OR WIFE <u>Augustus Austin</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>Augustus Austin</u> ^{Address} <u>4454 Vista Ave.</u>			
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>Congestive Heart Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost.		DUE TO (b) <u>Hypertensive Cardiovascular Disease</u>		DUE TO (c) <u>Generalized Arteriosclerosis</u>		3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Left Hemiplegia due to Cerebral Thrombosis - 3 yrs.</u>						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.) <u>443 x</u>					
20c. TIME OF INJURY Hour a.m. p.m.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21. I attended the deceased from <u>December 15, 1955</u> to <u>October 5, 1958</u> and last saw her/him alive on <u>October 5, 1958</u> Death occurred at <u>7:10 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>John W. Beckham, M.D.</u> (Degree or title)				22b. ADDRESS <u>5800 Arsenal St.</u>		22c. DATE SIGNED <u>10/6/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)		
<u>Burial</u>		<u>10-8-58</u>	<u>Lakewood Park</u>		<u>St. Louis, Mo.</u>		
24. FUNERAL DIRECTOR <u>Rowland-Aker, St. Louis, Mo.</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>OCT 8 '58</u>		26. REGISTRAR'S SIGNATURE <u>J. Carl Smith MO</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *Francis M. Della*

Licensed Embalmer No. *4375*

P. O. Address *St. Charles, 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.