

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037609

STATE FILE NUMBER

FILED OCT 23 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9793

S. 300
1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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, MISSOURI		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) 04 HOSPITAL OR INSTITUTION BARNES HOSPITAL			Length of stay in lb 2 1/2 59		d. STREET ADDRESS (If outside, give location) 4101 50 GRAND		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DAVID Middle LESTER Last BISHOP				4. DATE OF DEATH Month OCTOBER Day 11 Year 1958				
5. SEX MALE	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 JUNE 15 1912		9. AGE (In years last birthday) 46	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) TAVERN OPERATOR			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? U-S-A	
13a. FATHER'S NAME FREDERICK BISHOP			13b. MOTHER'S MAIDEN NAME CARRIE GRASLE			14. NAME OF HUSBAND OR WIFE EYTHEL BISHOP		
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. 497-03-3673		17. INFORMANT Address EYTHEL BISHOP 4101 50 GRAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aneurysm of thoracic aorta with dissection							INTERVAL BETWEEN ONSET AND DEATH years ?	
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)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)					
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.								
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 DEC. 16, 1958 to NOV. 11, 1958 and last saw her alive on NOV. 11, 1958 Death occurred at 8:38 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Name or title) Edward Massie M. D.				22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED OCT 14 '58		
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE OCT. 14 1958	23c. NAME OF CEMETERY OR CREMATORY SUNSET BURIAL PARK		23d. LOCATION (City, town, or county) ST. LOUIS, Co., Mo		(State)	
24. FUNERAL DIRECTOR Thomas Kutis 2906 Gravoia				25. DATE RECD. BY LOCAL REG. OCT 14 '58		26. REGISTRAR'S SIGNATURE J. Earl Smith, m.d. m.g.B.		

STATE OF MISSOURI

DEPARTMENT OF HEALTH

OFFICE OF THE COMMISSIONER

OF HEALTH

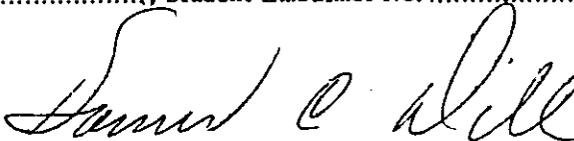
OF THE STATE

OF MISSOURI

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 

OFFICE OF THE COMMISSIONER

OF HEALTH

Licensed Embalmer No. 4347

P. O. Address 2906 Grand

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.