

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038217
STATE FILE NUMBER

FILED OCT 17 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9579

5. 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 checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 25 HOSPITAL ST. LOUIS CITY HOSP. #1		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 2237 2611 South 18th.
3. NAME OF DECEASED (Type or print) First MIDDLE Last POLLYANN SIAR		4. DATE OF DEATH Month Day Year 10 4 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-23-1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Unknown	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Martin	
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. ?	17. INFORMANT Martin Siar, Rt. #1 Box # 163-Fenton, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelo nephritis Bilateral DUE TO (b) Pyelonephritis B. lateral DUE TO (c) Undifferentiated Carcinoma of Bladder			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease and 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.) 1810	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 8/22/58 to 10/1/58 and last saw her/him alive on 10/1/58		Death occurred at 10:16 P m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE Edgar B. Cutter MD		22b. ADDRESS 1515 LAFAYETTE	
22c. DATE SIGNED 10-6-58		23a. BURIAL, CREMATION, REMOVAL (Specify)	
23b. DATE 10-7-1958		23c. NAME OF CEMETERY OR CREMATORY St. Trinity Lutheran	
23d. LOCATION (City, town, or county) St. Louis County, Mo.		23e. (State)	
24. FUNERAL DIRECTOR McLAUGHLIN'S, 2301 Lafayette		25. DATE RECD. BY LOCAL REG. OCT 6 '58	
26. REGISTRAR'S SIGNATURE Karl Smith MD		26. REGISTRAR'S SIGNATURE mbs	

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 *Joseph R. Chapman*

Licensed Embalmer No. *4550*

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.