Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-041288
STATE FILE NUMBER

FILED NOV 18 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9259

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St.Louis,Mo. — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION: Missouri Baptist Hospital — Length of stay in 1b: 2days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St.Louis
c. CITY OR TOWN: Ferguson — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 10077 Duke Dr. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Alvena Middle: Last: Best
4. DATE OF DEATH Month Day Year: Sept. 25, 1958
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec.14,1906
9. AGE (In years last birthday): 51 — 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): Nurse (ret)
10b. KIND OF BUSINESS OR INDUSTRY: Day Nursery
11. BIRTHPLACE (City and state or country): Mt.Olive,Ill.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13a. FATHER'S NAME: Clarence Hand
13b. MOTHER'S MAIDEN NAME: Frieda Snuski
14. NAME OF HUSBAND OR WIFE: Arra Best
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 344-24-1632
17. INFORMANT: Mr.Arra Best Address: 10077 Duke Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Monocytic leukemia — INTERVAL BETWEEN ONSET AND DEATH: 4yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 204.2 A
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Pulmonary tuberculosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 Jan.1,1952, to Sept.25,1958 and last saw her alive on Sept.24,1958
Death occurred at 1:45A: m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Orville O. White M.D.
22b. ADDRESS: 2100 HUDSON DR. ST LOUIS CO.
22c. DATE SIGNED: 9-25-58

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: 9-27-58
23c. NAME OF CEMETERY OR CREMATORY: Memorial Park Cemetery
23d. LOCATION (City, town, or county) MO. (State): St.Louis Co.,Mo.

24. FUNERAL DIRECTOR: Drehmann-Harral ADDRESS: 1905 Union Blvd.
25. DATE RECD. BY LOCAL REG.: 9-26-58
26. REGISTRAR'S SIGNATURE: J Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 Warren A. Carr

Licensed Embalmer No. 353X

P. O. Address .....

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.