

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

58-041409

FILED NOV 18 1958

Registration District No.

318

Primary Registration District No.

1003

STATE FILE NUMBER

10045

Registrar No.

300
 1-57

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
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 Richmond Heights 4505 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital		Length of stay in 1b DOA	d. STREET ADDRESS (If outside, give location) 27 1075 Terrace Drive Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last SOPHIE T. CLEVELAND			4. DATE OF DEATH Month Day Year Oct. 22, 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 21, 1884
9. AGE (In years last birthday) 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	11. BIRTHPLACE (City and state or country) Thompson, Mo.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown	14. NAME OF HUSBAND OR WIFE ? Cleveland
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. No	17. INFORMANT Edmund Dearborn, 1075 Terrace Dr., Richmond Hts
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>Coronary Thrombosis</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Arterio Sclerotic Heart Dis</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 20 min
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.) 420.0	
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 Death occurred at <i>March 1948</i> to <i>Oct. 22, 1958</i> and last saw her alive on <i>Oct. 10, 1958</i>			
22a. SIGNATURE (In ink) <i>H. J. Houch</i>		22b. ADDRESS <i>8902 Review Blvd</i>	22c. DATE SIGNED <i>10-22-58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/24/58	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
23d. LOCATION (City, town, or county) St. Louis, Mo.			
24. FUNERAL DIRECTOR <i>Louis H. Propp, Inc. Kirkwood, Mo.</i>		25. DATE RECD. BY LOCAL REG. OCT 22 '58	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i> S.P.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Francis J. Wyland Jr.*
Licensed Embalmer No. *4512*

P. O. Address *Hickory, N.C.*

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.