

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-042188

STATE FILE NUMBER

FILED NOV 20 1958

Registration District No. \_\_\_\_\_

318

Primary Registration District No. \_\_\_\_\_

1003

Registrar's No. \_\_\_\_\_

10877

300  
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTE <b>St. Louis City Hosp. #1</b>		Length of stay in lb <b>229</b>	d. STREET ADDRESS (If outside, give location) <b>2329 LaSalle St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Katie</b> Middle _____ Last <b>Sanders</b>			4. DATE OF DEATH Month <b>11</b> Day <b>8</b> Year <b>58</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>2 Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1895</b>	9. AGE (In years last birthday) <b>63</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>Mississippi</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Jim Mallet</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Deceased</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs. Beatrice Herron 2329 LaSalle St.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO (b) <b>all myocardial infarction</b> DUE TO (c) <b>Coronary arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>unk.</b> <b>unk.</b> <b>unk.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (not related to the terminal disease mentioned in PART I) (a) <b>mural thrombi, acute renal shut down, diabetes mellitus</b>		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.) <b>420.1</b>
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____
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20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from <b>11-5-58</b> to <b>11-8-58</b> and last saw her alive on <b>11-8-58</b> Death occurred at <b>8:35p.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Jean A. Chapman, M.D.</b> (Degree or title)	22b. ADDRESS <b>1515 Lafayette Ave.</b>	22c. DATE SIGNED <b>11-8-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11-15-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Dale Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
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24. FUNERAL DIRECTOR <b>G. Wade Granberry</b> ADDRESS <b>4202 Finney Ave.</b>	25. DATE RECD. BY LOCAL REG. <b>NOV 12 '58</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Always, however, use only standard embalmers' form. No applications should be made. 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 *Gayton Swann* .....

Licensed Embalmer No. 4580 .....

P. O. Address 4202 Finney Ave.

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.