

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-042773
STATE FILE NUMBER

FILED NOV 17 1958

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2818

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1. PLACE OF DEATH a. COUNTY St. Louis		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 Ladue		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Ladue 4421	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION #6 Wildrose Dr.		Length of stay in 1b years		d. STREET ADDRESS (If outside, give location) #6 Wildrose Dr.	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Rowland			4. DATE OF DEATH Month Day Year November 2, 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. 9, 1872	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		9. AGE (In years last birthday) 86	
11. BIRTHPLACE (City and state or country) Clay Co., Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.		13. MOTHER'S MAIDEN NAME Maria Moore	
13a. FATHER'S NAME John McCauley		14. NAME OF HUSBAND OR WIFE Richard Rowland		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. None		17. INFORMANT Address Mrs. Herbert Steinmeyer, #6 Wildrose Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage					INTERVAL BETWEEN ONSET AND DEATH 48 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					331X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 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 6-1-52 to 11-2-58 and last saw her alive on 11-2-58 Death occurred at 2:00 pm on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) M.D.			22b. ADDRESS 3903 Olive		22c. DATE SIGNED 11-2-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11-2-58		23c. NAME OF CEMETERY OR CREMATORY Haven Hill Cemetery	
				23d. LOCATION (City, town, or county) Olney, Ill.	
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd.			25. DATE RECD. BY LOCAL REG. 11-3-58		26. REGISTRAR'S SIGNATURE Herbert P. Soube, M.D.

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 *Stanley H. Dixon*

Licensed Embalmer No. *5193*

P. O. Address *St. H.*

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.