

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-042808
STATE FILE NUMBER

FILED NOV 17 1958 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2742

300
-57

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 Frontenac		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Frontenac 4000
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 801 Spode Road		Length of stay in lb 27 yrs	d. STREET ADDRESS (If outside, give location) 801 Spode Road
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last (Mother) Melanie Marie DeGourcy			4. DATE OF DEATH Month Day Year October 25th. 1958		
---	--	--	---	--	--

5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/17/1865	9. AGE (In years last birthday) 93	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) Religious	10b. KIND OF BUSINESS OR INDUSTRY Religious	11. BIRTHPLACE (City and state or country) Belgium	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	---	--	---

13a. FATHER'S NAME Ernest deGourcy	13b. MOTHER'S MAIDEN NAME Marie Camille de Sauvage-Vercour	14. NAME OF HUSBAND OR WIFE - - -
--	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no	16. SOCIAL SECURITY NO. no	17. INFORMANT Address Mother Hellmuth 801 Spode Road
---	--------------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular and renal disease	INTERVAL BETWEEN ONSET AND DEATH
--	----------------------------------

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	DUE TO (c) 4/2X
--	------------	------------------------

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) He sustained a fall in early Sept requiring prolonged hospital.	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 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 Sept 9-1958 to 10-23-58 and last saw her alive on 9-23-58 Death occurred at L.A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Dr. T. S. Coffey M.D.	22b. ADDRESS 634 N. Grand Blvd	22c. DATE SIGNED 10-25-58
--	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-27-1958	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Missouri
---	--------------------------------	---	--

24. FUNERAL DIRECTOR ADDRESS Arthur J. Donnelly 3840 Lindell Blvd.	25. DATE RECD. BY LOCAL REG. 10-25-58	26. REGISTRAR'S SIGNATURE Herbert K. Donnelly 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 *[Handwritten Signature]*

Licensed Embalmer No. *4699*

P. O. Address *3840 Lindell*

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.