

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-045507

STATE FILE NUMBER

1003

11461

FILED DEC 22 1958 Registration District No. 318 Primary Registration District No. Registrar

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>JEFFERSON</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>FESTUS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Missouri Baptist Hosp.</u>			Length of stay in lb <u>4 Day</u>		d. STREET ADDRESS (If outside, give location) <u>29 N. 5th ST.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>EDITH</u> Middle <u>B.</u> Last <u>CHOLLET</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 15, 1894</u>		9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>KEOKUK, IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>BEN CROWELL</u>				14. MOTHER'S MAIDEN NAME <u>MARY ALEXANDER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Genevieve Wagner - Festus, Mo.</u>		Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C.S. Heart Disease</u> <u>420.0</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							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 _____ a. m. _____ p. m. _____							
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
21. I attended the deceased from <u>11/23/58</u> to <u>11/26/58</u> and last saw her/him alive on <u>11/26/58</u> Death occurred at <u>9 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>[Signature]</u> (Degree or title)				22b. ADDRESS <u>919 N. Taylor</u>		22c. DATE SIGNED <u>11/29/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>11-29-58</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>PARK LAWN</u>		23d. LOCATION (City, town, or county) (State) <u>LeMay Mo.</u>		
24. FUNERAL DIRECTOR <u>JAMES R. Cady</u> ADDRESS <u>CRYSTAL CITY, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>NOV 28 '58</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service  
300 1-56  
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *James Richard Cady* .....  
Licensed Embalmer No. *43* .....  
P. O. Address *CRYSTAL* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.