

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-006859  
STATE FILE NUMBER  
2 1125  
Registrar's No.

300  
1-57  
07  
991  
0

FILED FEB 17 1959 Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Christian Hospital		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 4362 McPherson
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last Helen Margaret Andrus			4. DATE OF DEATH Month Day Year Jan. 29, 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April, 25, 1930	9. AGE (In years last birthday) 28	IF UNDER 1 YEAR Months Days Hours Min.

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	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME William E. Maysey	13b. MOTHER'S MAIDEN NAME Margaret Pierce	14. NAME OF HUSBAND OR WIFE Shirley
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No. Nil.	16. SOCIAL SECURITY NO. None	17. INFORMANT Shirley Andrus, 4362 McPherson, Av.	Address
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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) <i>Hemorrhoidosis</i> DUE TO (b) <i>Mediterranean Anemia</i> DUE TO (c) <i>29 2.2</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6-8 wks</i> <i>Congenital</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>She has been under my care and observation intermittently since 1949</i>		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.)
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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
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21. I attended the deceased from <u>January 1, 1959</u> to <u>January 29, 1959</u> last saw her alive on <u>1/29/59</u> Death occurred at <u>10:50 p.m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>Joshua E. Jensen M.D.</i>	22b. ADDRESS 607 N. Grand Ave.	22c. DATE SIGNED 1/31/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2-2-59	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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24. FUNERAL DIRECTOR Albert H. Hoop	ADDRESS 4700 Washington	25. DATE RECD. BY LOCAL REG. FEB 2 '59	26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. 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 *G. W. Wilkinson* .....

Licensed Embalmer No. *3575* .....  
P. O. Address *M. Louis* .....

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.