

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006994
STATE FILE NUMBER
2-1819

300
-526
291
5

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 _____

3. CITY OR TOWN **St. Louis** Inside Limits Yes No

4. DATE OF DEATH **Feb. 18, 1959** Month Day Year

5. FULL NAME OF (If NOT in hospital, give location) **St. L. City Hosp** Length of stay in 1b **65 Years**

6. STREET ADDRESS **5515 Pershing Ave** (If outside, give location) Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last **Bertha C Conway**

7. DATE OF BIRTH **Aug. 25, 1889** 8. AGE (In years last birthday) **69**

9. SEX **Female** **10. COLOR OR RACE** **White**

11. MARRIED NEVER MARRIED **12. WIDOWED** **3** **13. DIVORCED**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Solicitor - A.A.A.**

10b. KIND OF BUSINESS OR INDUSTRY **Amer. Auto. Assc.**

11. BIRTHPLACE (City and state or country) **Colorado**

12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **Murray Chappel** **13b. MOTHER'S MAIDEN NAME** **Henderson** **14. NAME OF HUSBAND OR WIFE** **None**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) **No** **None**

16. SOCIAL SECURITY NO. **495-18-2282** **17. INFORMANT** **Mrs Nettie Hasenpflug** Address **6010 Pershing**

18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Coronary thrombosis**
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) **Arterio sclerosis**
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____

19. INTERVAL BETWEEN ONSET AND DEATH _____

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT **SUICIDE** **HOMICIDE**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) **420.1**

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____

20d. INJURY OCCURRED WHILE AT WORK **NOT WHILE AT WORK**

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 _____ to _____ and last saw her alive on _____
Death occurred at _____ m of the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree of _____) **3** **22b. ADDRESS** **1300 Clark** **22c. DATE SIGNED** **2/20/59**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** **23b. DATE** **Feb. 23, 1959** **23c. NAME OF CEMETERY OR CREMATORY** **Sunset Burial Park** **23d. LOCATION** (City, town, or county) **St. Louis Co, Missouri** (State) _____

24. FUNERAL DIRECTOR **Alexander & Sons** **ADDRESS** **6175 Delmar Blv** **25. DATE RECD. BY LOCAL REG.** **FEB 20 '59** **26. REGISTRAR'S SIGNATURE** **Loan Smith, M.D.**

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 *Jos. E. McCulloch*

Licensed Embalmer No. *2760*

P. O. Address *L 1782*

**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.**