Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007833
STATE FILE NUMBER

FILED MAR 2 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 444

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN Clayton — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street location) St. Louis DOA Co Hospital — Length of stay in 1b D.O.A.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN Woodson Terrace 4000 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 4112 Edmundson — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First Margaret Middle Ann Last Andres
4. DATE OF DEATH Month 2 Day 13 Year 59
5. SEX Female
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH 8-14-1958
9. AGE (In years last birthday) IF UNDER 1 YEAR Months 5 Days 29 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child
10b. KIND OF BUSINESS OR INDUSTRY Child
11. BIRTHPLACE (City and state or country) St. Louis Co., Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Frank Andres
13b. MOTHER'S MAIDEN NAME Jo Ann Kiekle
14. NAME OF HUSBAND OR WIFE Never Married
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. None
17. INFORMANT Frank Andres Address 4112 Edmundson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Viral Pneumonia — 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)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 492X
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.)
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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at 9:01 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John C. Murphy M.D. (Degree or title) John C. Murphy MD Acting Health Commissioner
22b. ADDRESS 801 S.Brentwood Clayton
22c. DATE SIGNED 2/26/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 2-16-1959
23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery
23d. LOCATION (City, town, or county) Morrilton (State) Arkansas

24. FUNERAL DIRECTOR Jos.W.Clark F.H. ADDRESS 1125 Hodiamont
25. DATE RECD. BY LOCAL REG. 2-16-59
26. REGISTRAR'S SIGNATURE John C. Murphy, M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 Alfred F. Bredeker

Licensed Embalmer No. 2663

P. O. Address 1125 Hickman

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.