

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011358

STATE FILE NUMBER 2-2436

FILED MAR 20 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

300
-57
.7
25

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		Length of stay in lb 7 yrs.	
d. STREET ADDRESS 3225 Montgomery		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Benjamin Middle Frank Last Saville			4. DATE OF DEATH Month 3 Day 9 Year 59		
---	--	--	--	--	--

5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1881	9. AGE (In years, last birthday) 77	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)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Kan.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	-----------------------------------	---	---

13a. FATHER'S NAME Joseph Saville	13b. MOTHER'S MAIDEN NAME Lydia Wells	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)	16. SOCIAL SECURITY NO.	17. INFORMANT Chronic Hospital Records, 5800 Arsenal	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) Acute Pyelonephritis		INTERVAL BETWEEN ONSET AND DEATH 11 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	600.0
	DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Arteriosclerosis - 7 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---	--	---

20a. ACCIDENT <input checked="" 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 Topeka, Kansas.	COUNTY	STATE
---	--	--	--------	-------

21. I attended the deceased from 3-25-52 to 3-9-59 and last saw her alive on 3-9-59 Death occurred at 12:50 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.	
--	--

22a. SIGNATURE John W. Beckham, M.D.	(Degree or title)	22b. ADDRESS 5800 Arsenal	22c. DATE SIGNED 3/9/59
--	-------------------	-------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-9-59	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Topeka, Kansas.
---	----------------------------	------------------------------------	---

24. FUNERAL DIRECTOR Albert H. Hoppe	ADDRESS 4700 Washington Blvd	25. DATE RECD. BY LOCAL REG. MAR 9 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
--	--	--	--

All diseases in Part I must be causally related.

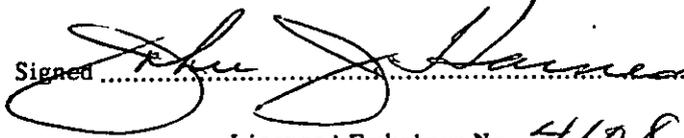
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 

Licensed Embalmer No. 4108

P. O. Address. St. Louis, Mo.

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.