

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011695

STATE FILE NUMBER

FILED APR 6 1958

Registration District No. 317

Primary Registration District No. 546

Registrar's No. 858

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN OVERLAND	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN OVERLAND 4071	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION WATKINS NURSING HOME	Length of stay in lb 170	d. STREET ADDRESS (If outside, give location) 9171 HAROLD DR.	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First FRANCES Middle APPLEGATE Last	4. DATE OF DEATH Month MARCH Day 27 Year 1959
---------------------------------------------------------------------------------------------	-----------------------------------------------------------------------

5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 5, 1868	9. AGE (In years last birthday) 90	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
----------------------	-------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------	-------------------------------------------	--------------------------------------------------	--------------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and state or country) ST. LOUIS, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
-----------------------------------------------------------------------------------------------------------------	--------------------------------------------------	---------------------------------------------------------------------	--------------------------------------------

13a. FATHER'S NAME NOT KNOWN	13b. MOTHER'S MAIDEN NAME NOT KNOWN	14. NAME OF HUSBAND OR WIFE HARRY E.
----------------------------------------	-----------------------------------------------	------------------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT HELEN L HORTON Address 9171 HAROLD DR.
-----------------------------------------------------------------------------------------------------------------------	----------------------------------------	-----------------------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent pneumonia	INTERVAL BETWEEN ONSET AND DEATH 10 hrs
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. DUE TO (b) Multiple cerebral vascular accidents 6 mos.	
DUE TO (c) Senescent capillary fragility	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4671	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 3 P.M. Month March Day 27 Year 1959

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION ST. LOUIS COUNTY ST. LOUIS STATE MO.
-------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------

21. I attended the deceased from Jan 1952 to March 27, 1959 and last saw her alive on March 26, 1959 Death occurred at 3 P.M. - March 27, 1959 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Fred A. Coates, M.D. (Degree or title)	22b. ADDRESS 2335 Brown Rd St. Louis 14	22c. DATE SIGNED March 28, 1959
-----------------------------------------------------------------	---------------------------------------------------	-------------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 3/30/1959	23c. NAME OF CEMETERY OR CREMATORY ST. MATTHEW'S CEM.	23d. LOCATION (City, town, or county) (State) ST. LOUIS, Mo.
-------------------------------------------------------------	-------------------------------	-----------------------------------------------------------------	------------------------------------------------------------------------

24. FUNERAL DIRECTOR J L ZIEGENHEIN & SONS ADDRESS 7027 GRAVOIS	25. DATE RECD. BY LOCAL REG. 3-30-59	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.
--------------------------------------------------------------------------------------	------------------------------------------------	---------------------------------------------------------

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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
[Handwritten Signature]

Licensed Embalmer No.
P. O. Address.....
[Handwritten Address]

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.