

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015900

STATE FILE NUMBER

2 3431

FILED APR 24 1959

Registration District No.

Primary Registration District No.

Registrar's

300

1-57

6

196

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.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hosp.		d. STREET ADDRESS (If outside, give location) 8112 Vulcan	
3. NAME OF DECEASED (Type or print) First Middle Last Ann Walsh		4. DATE OF DEATH Month Day Year Apr. 6, 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 20, 1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) S. Louis, Mo.
13a. FATHER'S NAME Thomas Walsh		13b. MOTHER'S MAIDEN NAME Ann Reilly	14. NAME OF HUSBAND OR WIFE none
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) no no		16. SOCIAL SECURITY NO. no	17. INFORMANT Florence Walsh 8112 Vulcan
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>Pneumonia - left lobar</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Arteriosclerosis -</i> DUE TO (c) <i>450.0</i>			INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs</i> <i>15 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c)			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 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
21. I attended the deceased from <i>15 March</i> to <i>death</i> and last saw her alive on <i>6 April 59</i> . Death occurred at <i>1030 a.m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>John St. Jelet MD</i>		22b. ADDRESS <i>2314 Delegraph</i>	22c. DATE SIGNED <i>7 April 59</i>
23a. BURIAL, CREMATION, or other disposition <i>removal</i>	23b. DATE <i>4-9-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olive Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Lemay 23, Mo.</i>
24. FUNERAL DIRECTOR ADDRESS <i>Southern Funeral Home 6322 S. Grand, St. Louis, Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>APR 8 '59</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

DR. KELLETT
2314 Teheran

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 *David W. Gosau*

Licensed Embalmer No. *4343*

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.