

Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019855

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1496

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kirkwood 4713</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis Co. Hosp. DOA</u>		Length of stay in lb	d. STREET ADDRESS <u>136 Prospect</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Pond</u> Last <u>Pond</u>			4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept-16, 1885</u>	9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Claude Pond</u>	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give nature of service) <u>None</u>	16. SOCIAL SECURITY NO. <u>490-40-2552</u>	17. INFORMANT <u>Rosemary Cuddahee-1038 Oakland Ave.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 to 10 years</u> <u>20 years -</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary insufficiency</u>	
	DUE TO (c) <u>Arteriosclerotic heart disease</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4200</u>		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 <u>          </u> Month, Day, Year a.m. <u>          </u> p.m. <u>          </u>	

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 <u>          </u> STATE <u>          </u>
21. I attended the deceased from <u>April 20, 1959</u> to <u>April 30, 1959</u> and last saw her/him alive on <u>April 30, 1959</u> . Death occurred at <u>home 7:45 a.m. May 31, 1959</u> on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>John J. Gomez</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>508 N. Grand Ave.</u>	22c. DATE SIGNED <u>6/1/59</u>

23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>June 2, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST PETER &amp; PAUL</u>	23d. LOCATION (City, town, or county) <u>ST. LOUIS, Mo.</u>
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24. FUNERAL DIRECTOR <u>Pfzinger Mort-Kirkwood 22, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>6-1-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

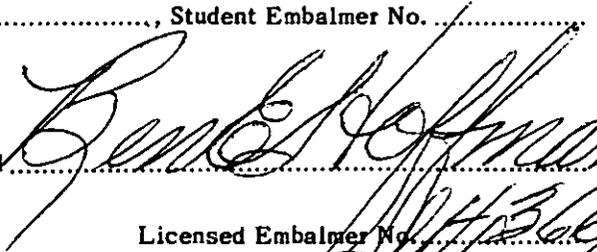
MEDICAL CERTIFICATION

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   
Licensed Embalmer No. ....  
P. O. 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.