

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-026552

STATE FILING NUMBER 2 6226

FILED VS AUG 3 1959

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

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>ST. LOUIS</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>MAPLEWOOD</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 City Hosp</u> | | Length of stay in 1b <u># 1 3-WKS</u> | d. STREET ADDRESS (If outside, give location) <u>7440 ZEPHYR</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna NMI Deyen</u> | | | 4. DATE OF DEATH Month Day Year <u>June 29th 1959</u> |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-24-1876</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years less birthday) <u>83</u> FUNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |
| <u>GENERAL-WORKSCHOOL-CAFETERIA</u> | | <u>CARLYLE, ILL</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13a. FATHER'S NAME <u>JOHN-DEYEN</u> | | 13b. MOTHER'S MAIDEN NAME <u>AMELIA-HESE</u> | 14. NAME OF HUSBAND OR WIFE <u>MAPLEWOOD, MO.</u> |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO.</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | 17. INFORMANT Address <u>MAPLEWOOD, MO.</u> <u>MRS. HELEN-BUENEMAN-2281-YALE</u> |
| 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>Cerebral Vascular Thrombosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>332x</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <u>June 6, 1959</u> to <u>June 29th, 1959</u> and last saw her alive on <u>June 29th, 1959</u> Death occurred at <u>4:26 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>Chas. W. Smith M.D.</u> (Deceased or title) | | 22b. ADDRESS <u>1515 Lafayette Ave</u> | 22c. DATE SIGNED <u>6-29 -59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town, or county) (State) |
| <u>BURIAL</u> | <u>7-3-59</u> | <u>CALVARY-CEMETERY</u> | <u>ST. LOUIS MISSOURI</u> |
| 24. FUNERAL DIRECTOR <u>TAY B. SMITH, MAPLEWOOD, MO.</u> | | 25. DATE RECD. BY LOCAL REG. <u>JUL 1 '59</u> | 26. REGISTRAR'S SIGNATURE <u>Chas. W. Smith, M.D.</u> |

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 *J. Allen Davis Jr.*

Licensed Embalmer No. *4053*

P. O. Address *St. Louis*

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.