

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034537

FILED OCT 13 1959

Registration District No. 317 Primary Registration District No. 531 Registrar's No. 2660

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) St. Louis Missouri ST LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN U. City	Length of stay in 1b YRS	c. CITY OR TOWN University City	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6630 Pershing		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6630 Pershing
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) MARGARET EMMA DAVAULT			4. DATE OF DEATH Month Day Year October 6 1959	
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/1/1866	9. AGE (last birthday) 92	IF UNDER 1 YEAR Months 10 Days 5 Hours Min. 	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (City and state or country) Marble Hill Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Geo Willigord	13b. MOTHER'S MAIDEN NAME Elizabeth Swift	14. NAME OF HUSBAND OR WIFE W.A. Davault
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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. no	17. INFORMANT Address Mrs Chas Wright 6630 Pershing
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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) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 70 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerotic vascular disease chr.	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from 1956 to Oct. 6 1959 and last saw her/him alive on 10 6 59	
Death occurred at 5:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) D.D. Scabacagh M.D.	22b. ADDRESS Webster Groves Mo.	22c. DATE SIGNED 10-6-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 10/8/59	23c. NAME OF CEMETERY OR CREMATORY Glen Allen	23d. LOCATION (City, town, or county) (State) Glen Allen Missouri
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24. FUNERAL DIRECTOR ADDRESS C.R. Lupton and Sons 7233 Delmar	25. DATE RECD. BY LOCAL REG. 10-6-59	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*Dr. Keating
165 W. Richmond, 3-5302
Davenport*

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 *Arnold W. Schoene*

Licensed Embalmer No. *3864*
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.