

**DURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-034661**

FILED VS SEP 16 1959

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 546 Registrar's No. 2412

MEMORANDUM

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ST. LOUIS</b>   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MO.</b> b. COUNTY <b>ST. LOUIS</b> |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>OVERLAND</b>  |   | Length of stay in 1b<br><b>7 Yrs.</b>   | c. CITY OR TOWN <b>OVERLAND (14)</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (if NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>6145 Gambeton Pl.</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>6145 Gambleton Pl.</b>  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Dee</b> Middle <b>L.</b> Last <b>WALDRON</b>  |   |   | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>6</b> Year <b>1959</b>  |  |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/25/72</b>  | 9. AGE (last birthday)<br><b>87</b>  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>FARMER</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>RETIRED</b>   | 11. BIRTHPLACE (City and state or country)<br><b>Randolph Co. Ark.</b>  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>   |   |
| 13a. FATHER'S NAME<br><b>Leslie Waldron</b>   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Matilda Mock</b>  |   | 14. NAME OF HUSBAND OR WIFE<br><b>Addie</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO.<br><b>?</b>   | 17. INFORMANT Address (21)<br><b>Lowel Waldron, 7833 Skyview Drive</b>  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ARTERIO SCLEROTIC HEART DISEASE</b>  |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>15 YRS</b>                                     |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 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<br>Hour _____ Month, Day, Year _____<br>a.m. _____ p.m. _____   |   |   |   |  |   |
| 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  |   |
| 21. I attended the deceased from <b>MAY 1, 1957</b> to <b>SEPT 6, 1959</b> and last saw him alive on <b>SEPT. 6, 1959</b><br>Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |   |  |   |
| 22a. SIGNATURE (Degree or title)<br><b>Dr. O. White MD</b>  |   |   | 22b. ADDRESS<br><b>2100 HUDSON DR</b>   | 22c. DATE SIGNED<br><b>9/8/59</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b>   | 23b. DATE<br><b>9/8/1959</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Masonic Cemetery</b>   | 23d. LOCATION (City, town, or county) (State)<br><b>Pocohontas, Arkansas</b>  |  |   |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>McLAUGHLIN'S, 2301 Lafayette Ave.</b>  |   | 25. DATE RECD. BY LOCAL REG.<br><b>9-8-59</b>   | 26. REGISTRAR'S SIGNATURE<br><b>John B. Murphy MD</b>   |  |   |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

O. WHITE  
2100 ...  
... 2:30 P.M.

**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 James R. Chapman  
Licensed Embalmer No. 4550  
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.