

FILED SEP 6 1949  
-JE 1870THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28783

BIRTH NO.		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 3069		Registrar's No. 2038	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
a. COUNTY		ST. Louis Co.		a. STATE		Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN		ST. Louis, Richmond, W. I. D. A.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN		LUTESVILLE 9	
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS			
ST. MARY'S HOSPITAL							
3. NAME OF DECEASED			4. DATE OF DEATH			5. SEX	
a. (First)			b. (Middle)			c. (Last)	
SOPHIA			CARDELIA			CHFOATE	
(Type or Print)			6. DATE OF BIRTH			7. AGE (In years last birthday)	
F			W			72	
8. COLOR OR RACE			9. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)			10. DATE OF BIRTH	
W.			WIDOWED			APR. 23, 1877	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)	
H.W.F.						ROLLINGER Co., Mo.	
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE	
WILEY SCOTT			MARY MYERS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT'S SIGNATURE OR NAME	
No.			NONE			MRS. ORA ABERNATHY LUTESVILLE	
(If yes, give war or dates of service)						ADDRESS	
18. CAUSE OF DEATH			MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)			I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)			Cerebral Vasculer Hemorrhage 3M	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.			ANTECEDENT CAUSES			10 days.	
			Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				
			DUE TO (b) Arteriosclerosis				
			DUE TO (c)				
			II. OTHER SIGNIFICANT CONDITIONS			331X	
			Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from August 10, 1949, to August 11, 1949, that I last saw the deceased alive on August 11, 1949, and that death occurred at 1:55 p. m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title)				23b. ADDRESS		23c. DATE SIGNED	
William A. Keight J. M. D.				Mrs. Eleanor Riley		8/22/49	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)	
BURIAL		AUG. 14, 1949		BAKER CEMETERY		LUTESVILLE, Mo.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
8-24-49		Robert P. Smith, D.D.		BAKER FUNERAL HOME, LUTESVILLE, Mo.			

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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 .....  
Student Embalmer

Signed

*J. E. Graham*

Licensed Embalmer No. *4010*

P. O. Address *Luttrell, W. Va.*

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 this body is not embalmed, fact should be so stated above.