

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **27309**

FILED JUL 23 1953

 BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 1956

1. PLACE OF DEATH a. COUNTY <b>St. Louis Co., Mo.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>BELLE FONTAINE</b>		c. LENGTH OF STAY (In this place) <b>3 MONTHS</b>		c. CITY OR TOWN <b>BELLE FONTAINE</b>		d. RESIDENCE WITHIN LIMITS OF A CITY OR INCORPORATED TOWN? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>10011 Monarch Drive</b>				e. STREET ADDRESS (If rural, give location) <b>10011 Monarch Drive</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Rose</b> b. (Middle) <b>Mackey</b> c. (Last) <b>Mackey</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>7/14/53</b>				
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>		8. DATE OF BIRTH <b>Mar. 30, 1888</b>	
9. AGE (In years last birthday) <b>65</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>30</b>		IF UNDER 24 HRS. Hours <b></b> Mins. <b></b>		11. BIRTHPLACE (City and State or Foreign Country) <b>North Dakota</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John Dinham</b>			13b. MOTHER'S MAIDEN NAME <b>Annie Powers</b>			14. NAME OF HUSBAND OR WIFE <b>Deceased</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Harry Batavia</b> ADDRESS <b>4602 Korte</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary of Liver</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Asites</b> DUE TO (c) <b>Cerebral Arterio Sclerosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6-7-53</b>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>5810</b>					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 <b>April, 1953</b> , to <b>July 14, 1953</b> , that I last saw the deceased alive on <b>July 14, 1953</b> , and that death occurred at <b>5 P.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Wm. P. Hamilton M.D.</b> (Degree or title)				23b. ADDRESS <b>836 3 Hills Ferry Rd</b>		23c. DATE SIGNED <b>7-15-53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>7/17/53</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>	
DATE REC'D BY LOCAL REG. <b>7-15-53</b>		REGISTRAR'S SIGNATURE <b>Herbert R. Donke M.D.</b>			25. FUNERAL DIRECTOR'S SIGNATURE <b>Sullivan's Euclid at St. Louis</b> ADDRESS		

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....  
Signature of Student Embalmer

Signed..... *Anthony Bonn* .....

Licensed Embalmer No. *4615* .....

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.