

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 26 1954

State File No. 35659

318

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo.</u>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>St. Louis,</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>1414 Warren St.</u>				e. STREET ADDRESS (If rural, give location) <u>26 1414 Warren St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Lena</u>		b. (Middle) <u>Frances</u>		c. (Last) <u>McCullough</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 3, 1954</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 13, 1904</u>		9. AGE (In years last birthday) <u>50</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home.</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>New Baden, Illinois,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Yost</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Lollis</u>		14. NAME OF HUSBAND OR WIFE <u>Cecil McCullough</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>Nil.</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Cecil McCullough, 1414 Warren St.</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Heart disease</u>				DUE TO (b) _____			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____				II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes Mellitus.</u>			
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) <u>4200</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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 <u>10/3, 1954</u> , to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>8:28 p.m.</u> , from the causes and on the date stated above.							
23. SIGNATURE (Degree or title) <u>Paul J. Bettowille M.D.</u>				23b. ADDRESS <u>1414 Warren</u>		23c. DATE SIGNED <u>10/4/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>10-4-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>New Baden, Illinois,</u>		
DATE REC'D BY LOCAL REG. <u>OCT 4 1954</u>		REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Hempen, Funeral Home, New Baden, Ill.</u>			

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

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.....
Licensed Embalmer No.....

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.**