

FILED FEB 21 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6581

State File No.

318

1003

1392

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 Mo.				b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 0		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>				
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony Hospital				e. STREET ADDRESS (If rural, give location) 4189 4249a Arco Ave.						
3. NAME OF DECEASED (Type or Print) EFFIE		a. (First)		b. (Middle) BEATRICE		c. (Last) VAN DOVER		4. DATE OF DEATH (Month) (Day) (Year) Feb. 13 1955		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced		8. DATE OF BIRTH April 25, 1894		9. AGE (In years last birthday) 60 if UNDER 1 YEAR Months Days if UNDER 1 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Invalid-Housework			10b. KIND OF BUSINESS OR INDUSTRY At Home			11. BIRTHPLACE (City and State or Foreign Country) Johnson County, Ill.!			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME John Albright			13b. MOTHER'S MAIDEN NAME Nancy Walker			14. NAME OF HUSBAND OR WIFE Roy VanDover				
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. None			17. INFORMANT'S SIGNATURE OR NAME Viola VanDover			ADDRESS 4249a Arco Ave.	
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) <u>Arteriosclerotic heart disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH 4 yrs.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION None						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) None		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4200						
22. I hereby certify that I attended the deceased from <u>Aug</u> , 19 <u>51</u> , to <u>Feb. 13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Feb 13</u> , 19 <u>55</u> , and that death occurred at <u>9:35 A</u> m., from the causes and on the date stated above.										
23a. SIGNATURE <u>R.V. Powell M.D.</u>				(Degree or title)		23b. ADDRESS <u>3720 Washington St.</u>		23c. DATE SIGNED <u>2/14/55</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Feb. 16, 1955		24c. NAME OF CEMETERY OR CREMATORY Laurel Hills		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.				
DATE REC'D BY LOCAL REG. FEB 14 1955		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Kriegshauser 4228 S. Kingshighway Bl.</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 emb
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *William B White*.....

Licensed Embalmer No. *429*

P. O. Address *4228 N. K...*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.