

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20332

FILED JUN 22 1955

BIRTH NO. 39661-55 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5040

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. LENGTH OF STAY (in this place) Life	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. LOUIS CITY HOSPITAL			f. STREET ADDRESS (If rural, give location) 26 2508 N. 11th		
3. NAME OF DECEASED (Type or Print) ALICE			a. (First)	b. (Middle) F.	c. (Last) PRESSON
4. DATE OF DEATH JUNE 9, 1955			(Month)	(Day)	(Year)
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH JUNE 7, 1955	9. AGE (In years last birthday) 2	IF UNDER 1 YEAR Months
IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Mins.	11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS, MISSOURI		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME DICK PRESSON		13b. MOTHER'S MAIDEN NAME NELLIE BRESHEARS		14. NAME OF HUSBAND OR WIFE NONE	
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 ADDRESS HOSPITAL RECORD	
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) Prematurity ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)		
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)		21f. HOW DID INJURY OCCUR? 776X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from 6-7-55, 19, to 6-9-55, 19, that I last saw the deceased alive on 6-9-55, 19, and that death occurred at 11:30P.M., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Mary A. Davis, M.D.			23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 6-10-55
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 6-10-1955	24c. NAME OF CEMETERY OR CREMATORY National Cemetery	24d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.	
DATE REC'D BY LOCAL REG. JUN 10 1955		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McLaughlin F.H., Inc. 2301 Lafayette	

(Licensed Embalmer's Statement on Reverse Side)

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 Not Emb., Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed H. L. Farris

Licensed Embalmer No. 336
P. O. Address H. L. Farris

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.