

FILED JUN 30 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20547**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **541** Registrar's No. **1296**

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY ST. LOUIS | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY ST. LOUIS | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CLAYTON | | c. CITY OR TOWN OVERLAND | |
| c. LENGTH OF STAY (In this place) 4 hrs. | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS COUNTY HOSP. | | STREET ADDRESS (If rural, give location) 10580-MERT AVE | |

| | |
|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) Cashion c. (Last) | 4. DATE OF DEATH (Month) (Day) (Year) 6 4 55 |
|--|--|

| | | | | | | | | |
|----------------------|-------------------------------|--|-------------------------------------|---|------------------------|-----------------------|------------------------|-----------------------|
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH OCT. 5-1878 | 9. AGE (In years last birthday) 76 | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | IF UNDER 60 MIN. Hours | IF UNDER 15 MIN. Min. |
|----------------------|-------------------------------|--|-------------------------------------|---|------------------------|-----------------------|------------------------|-----------------------|

| | | | |
|---|---|---|--|
| 10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) HOUSEWIFE | 10b. KIND OF BUSINESS OR INDUSTRY HOME | 11. BIRTHPLACE (City and State or Foreign Country) WITTENBURG, MO. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
|---|---|---|--|

| | | |
|--|---|--|
| 13a. FATHER'S NAME OLIVER GREEN | 13b. MOTHER'S MAIDEN NAME ELLEN McDOWELL | 14. NAME OF HUSBAND OR WIFE GEORGE DCD. |
|--|---|--|

| | | |
|--|-------------------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) NO | 16. SOCIAL SECURITY NO. NONE | 17. INFORMANT'S SIGNATURE OR NAME Verona Christensen ADDRESS 10580 MERT 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, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular accident | | INTERVAL BETWEEN ONSET AND DEATH |
| | 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. | | |

| | | |
|------------------------|----------------------------------|--|
| 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 **6-4**, 19**55**, to **6-4**, 19**55**, that I last saw the deceased alive on **6-4**, 19**55**, and that death occurred at **5:00 P.m.**, from the causes and on the date stated above.

| | | |
|--|------------------------------------|--------------------------------|
| 23a. SIGNATURE G.E. Smith, M.D. (Degree or title) | 23b. ADDRESS 6015 Brentwood | 23c. DATE SIGNED 6/4/55 |
|--|------------------------------------|--------------------------------|

| | | | |
|---|---------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 6-7-1955 | 24c. NAME OF CEMETERY OR CREMATORY MT. HOPE CEMETERY | 24d. LOCATION (City, town, or county) (State) LEMAY, MO. |
|---|---------------------------|---|---|

| | | |
|--|---|---|
| DATE REC'D BY LOCAL REG. 6-7-55 | REGISTRAR'S SIGNATURE Harbert R. Douke | 25. FUNERAL DIRECTOR'S SIGNATURE William Brown ADDRESS 2504-WOODSON RD. OVERLAND, MO. |
|--|---|---|

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 *David C. Gibson*

Licensed Embalmer No. *345*

P. O. Address *Osborne*

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.