

FILED SEP 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31002

State File No. _____

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 7554		
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) _____		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 (If not in hospital or institution, give street address or location) 5657 Enright avenue				e. STREET ADDRESS (If rural, give location) 5657 Enright avenue <i>205/10</i>				
3. NAME OF DECEASED (Type or Print) a. (First) CAROL b. (Middle) F. c. (Last) HOLT			4. DATE OF DEATH (Month) (Day) (Year) 8-25-55					
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH 9-30-1874		9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired real estate			10b. KIND OF BUSINESS OR INDUSTRY Realtor		11. BIRTHPLACE (City and State or Foreign Country) Lebanon, Illinois		12. CITIZENRY OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Charles Holt			13b. MOTHER'S MAIDEN NAME Sarah Ann Tabb		14. NAME OF HUSBAND OR WIFE unknown			
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 John Holt, Mt. Vernon, Illinois				
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				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis				DUE TO (b) Hypertension.				5 yrs.
ANTECEDENT CAUSES				DUE TO (c) _____				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Thrombosis iliac vein								9 days
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) 443 x				
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 _____, 1957, to 8-25 , 1955, that I last saw the deceased alive on 8-25 , 1955, and that death occurred at 12 P. M. , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) Philip Schuck M.D.				23b. ADDRESS 1703 S. Spruce		23c. DATE SIGNED 8.27.55		
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 8-26-55	24c. NAME OF CEMETERY OR CREMATORY Mt. Vernon, Illinois		24d. LOCATION (City, town, or county) (State) Mt. Vernon, Illinois			
DATE REC'D BY LOCAL REG. AUG 29 1955		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Myer, Mt. Vernon, Illinois				

(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 emb

by me, or by Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Francis J. Wyland Jr*.....

Licensed Embalmer No. *45*.....

P. O. Address *St. Louis*.....

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.