

THE DIVISION OF HEALTH OF MISSOURI
FILED SEP 29 1955 STANDARD CERTIFICATE OF DEATH

State File No. **31277**
Registrar's No. **8117**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH
a. COUNTY _____

2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission).
a. STATE **MISSOURI**
b. COUNTY _____
c. CITY OR TOWN **ST LOUIS**
d. Is residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION **1431 UNION BLVD**
e. STREET ADDRESS (If rural, give location) **1431 UNION BLVD 206/6**

3. NAME OF DECEASED
a. (First) **Rose F.** b. (Middle) **Myers** c. (Last) _____
4. DATE OF DEATH (Month) (Day) (Year) **Sept 14, 1955**

5. SEX **FEMALE** 6. COLOR OR RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **WIDOW** 8. DATE OF BIRTH **Sept 27-1882** 9. AGE (In years last birthday) **72** 11 Months **11** Days **23** Hours **13** Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Nurse** 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and State if Foreign Country) **DENNISON, TEXAS** 12. CITIZEN OF WHAT COUNTRY? _____

13a. FATHER'S NAME **JOHN COLLINS** 13b. MOTHER'S MAIDEN NAME (If known) **MARGARET COLLINS** 13c. NAME OF HUSBAND OR WIFE **DECEASED**

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. **492-32-254** 17. INFORMANT'S SIGNATURE OR NAME **Mrs Margaret Nichols** ADDRESS **1431 UNION**

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **hypertensive, cardio-vascular renal disease**
ANTECEDENT CAUSES _____ DUE TO (b) _____
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.

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION **442x** 20. AUTOPSY? YES NO

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) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from **Dec 1**, 19**53**, to **Sept 14**, 19**55**, that I last saw the deceased alive on **Sept 13**, 19**55**, and that death occurred at **6:00 am.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **Rue G McJorney MD** 23b. ADDRESS **5014 Sheila Florida** 23c. DATE SIGNED **9/14/55**

24a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** 24b. DATE **Sept 16 55** 24c. NAME OF CEMETERY OR CREMATORY **BELLEFONTAINE** 24d. LOCATION (City, town, or county) (State) **ST LOUIS MISSOURI**

DATE REC'D BY LOCAL REG. **SEP 15 1955** REGISTRAR'S SIGNATURE **J. Carl Smith MD** FUNERAL DIRECTOR'S SIGNATURE **Nichols** ADDRESS **1431 UNION**

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 *J Wm Binkley*

Licensed Embalmer No. *365*

P. O. Address *St Louis*

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.