

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43458

State File No. _____

FILED JAN 25 1956

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11585**

1. PLACE OF DEATH a. COUNTY _____				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 St. Louis, Mo.		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN 4376 University City/5.		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL				e. STREET ADDRESS (If rural, give location) #846cWarder Avenue,					
3. NAME OF DECEASED (Type or Print) a. (First) John			b. (Middle) Eustace		c. (Last) Hallett		4. DATE OF DEATH (Month) (Day) (Year) Dec. 31, 1955		
5. SEX Male		6. COLOR OR RACE White.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married.		8. DATE OF BIRTH March 31, 1890.		9. AGE (In years last birthday) Months Days Hours Min. 65.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sup't Meter Readers.				10b. KIND OF BUSINESS OR INDUSTRY Laclede Gas Co.,		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME John Hallett.			13b. MOTHER'S MAIDEN NAME Nellie Eustace.			14. NAME OF HUSBAND/OR WIFE Ruth Wilson Hallett.			
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. no.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs J. E. Hallett #846 Warder 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) Myocardial Infarction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Thrombosis & Arteriosclerosis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 420.1				INTERVAL BETWEEN ONSET AND DEATH Yrs.	
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) m.			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 Dec. 8, 1955 , to Dec. 31, 1955 , that I last saw the deceased alive on Dec. 31, 1955 , and that death occurred at 5:25 a.m. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) C. P. Vermillion, M.D.					23b. ADDRESS BARNES HOSPITAL		23c. DATE SIGNED 12/31/55		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Jan'y 3, 1956		24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery.		24d. LOCATION (City, town, or county) (State) #7600 St. Charles Rock Road.			
DATE REC'D BY LOCAL REG. JAN 3 1956			REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C.R. Lupton & Sons #7233 Delmar Blv'd.,				

(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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Arnold W. Schoene*.....

Licensed Embalmer No. *3864*.....

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.