

FILED MAR 7 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 7174

Registrar's No. 1444

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. 7174		Registrar's No. 1444						
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 town) OR TOWN St. Louis				c. LENGTH OF STAY (in this place) 1 WK		c. CITY OR TOWN Ferguson, Mo		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 De Paul Hospital				e. STREET ADDRESS (If rural, give location) 425 Tiffin										
3. NAME OF DECEASED (Type or Print) a. (First) ANNABEL			b. (Middle) HUBBARD			c. (Last) SCHLICHTING			4. DATE OF DEATH (Month) (Day) (Year) Feb. 8, 1956					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Aug. 12, 1888			9. AGE (In years last birthday) 67		F UNDER 1 YEAR Months Days		F UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and State or Foreign Country) Port Hope, Michigan				12. CITIZEN OF WHAT COUNTRY? USA				
13a. FATHER'S NAME David McFawn				13b. MOTHER'S MAIDEN NAME Harriet Sinclair				14. NAME OF HUSBAND OR WIFE Arthur F. Schlichting						
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 A. F. Schlichting, 425 Tiffin								
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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion & myocardial infarction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive cardiac vascular disease DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								INTERVAL BETWEEN ONSET AND DEATH 7 days		
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) _____		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 Oct, 1954, to Feb, 1956, that I last saw the deceased alive on Feb, 1956, and that death occurred at 2:10 p.m., from the causes and on the date stated above.														
23a. SIGNATURE Joseph A. Smith (Degree or title) MD				23b. ADDRESS 2122. PROVISION ST Ferguson, Mo				23c. DATE SIGNED 2/9/56						
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24b. DATE 2-11-56		24c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory			24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri							
DATE REC'D BY LOCAL REG. FEB 10 1956		REGISTRAR'S SIGNATURE [Signature]				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS WHITE CHAPEL, FERGUSON, MISSOURI								

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 *Eleana Province*.....

Licensed Embalmer No. 3403.....

P. O. Address Jennings, Mo.....

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.