

FILED MAR 26 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10829

State File No.

318

PRIMARY REG. DIST. NO.

1003

Registrar's No.

2243

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) 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 Mapelwood ⁴⁵²⁴		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) 7806 Alicia Ave.					
3. NAME OF DECEASED (Type or Print) a. (First) Lenora b. (Middle) M. c. (Last) Hathaway			4. DATE OF DEATH (Month) (Day) (Year) March 1, 1956						
5. SEX Female <input checked="" type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 13, 1890		9. AGE (in years last birthday) 65	IF UNDER 1 YEAR Months Days	IF UNDER 1 HR. 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) Ottawa, Ohio		12. CITIZEN OF WHAT COUNTRY? U. S.			
13a. FATHER'S NAME John Smith			13b. MOTHER'S MAIDEN NAME Myrtle Maxwell		14. NAME OF HUSBAND OR WIFE Charles F. Hathaway				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, specify or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Robert A. Hathaway, Ferguson, Mo					
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 ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 331X				INTERVAL BETWEEN ONSET AND DEATH 4-5 days 2 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)		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 Feb. 27, 1956, to March 1, 1956, that I last saw the deceased alive on March 1, 1956, and that death occurred at 4:30 A.M., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) R. Masley M. D.				23b. ADDRESS BARNES HOSPITAL		23c. DATE SIGNED 3/1/56			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 3/3/56	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.		24d. LOCATION (City, town, or county) (State) Normandy, Mo.				
DATE REC'D BY LOCAL REG. MAR 2 1956		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS WHITE CHAPEL, FERGUSON, MO.					

(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 *Elena Province*.....

Licensed Embalmer No. *340*.....

P. O. Address *Jermy*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.