THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JUN 14 1956

STATE FILE NUMBER 18265

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5007

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, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St. Louis, — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST. LOUIS CITY HOSPITAL #1. — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 530 N. Spring — Reside on Farm Yes ☐ No ☒

19 2199

3. NAME OF DECEASED (Type or print)	First: Nonie	Middle:	Last: MC LAIN
4. DATE OF DEATH	Month: MAY	Day: 22	Year: 1956
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: May 9, 1874
9. AGE (In years last birthday): 82	IF UNDER 1 YEAR: Months / Days	IF 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: At Home	11. BIRTHPLACE (City and state or country): Chester, Illinois,	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles McFadden		14. MOTHER'S MAIDEN NAME: Sarah DeRousse	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service) Nil	16. SOCIAL SECURITY NO. —	17. INFORMANT Address: Jean Matthias, Ottawa, Illinois,	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive Heart Failure

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Arteriosclerotic Heart Disease

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pernicious Anemia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

420.0

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 4/10/56, to 5/22/56 and last saw her/him alive on 5/22/56

Death occurred at 8:30 P.M m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): William N. Blalock, M.D.	22b. ADDRESS: 1515 LAFAYETTE AVE.	22c. DATE SIGNED: 5/23/56.
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal	23b. DATE: 5-24-56	23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) (State): Ste Genevieve, Mo.		
24. FUNERAL DIRECTOR ADDRESS: Albert H. Hoppe 4700 Washington,	25. DATE RECD. BY LOCAL REG.: MAY 24 1956	26. REGISTRAR'S SIGNATURE: J. Earl Smith, M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

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

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Robert M. Murray

Licensed Embalmer No.....

P. O. Address St. Louis

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.