

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **19192**

BIRTH NO. _____		REG. DIST. NO. 517		PRIMARY REG. DIST. NO. 500		Registrar's No. 1209				
1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO				b. COUNTY St. Louis		
b. CITY OR TOWN Koch - MO		c. LENGTH OF STAY (in this place) 13 day		c. CITY OR TOWN St. Louis		d. Is Residence within limits of city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
d. FULL NAME OF HOSPITAL OR INSTITUTION Robert Koch Hospital				e. STREET ADDRESS (If rural, give location) 5050 Union				2099		
3. NAME OF DECEASED (Type or Print) a. (First) Nelson			b. (Middle) Kidder		c. (Last) Healy		4. DATE OF DEATH (Month) (Day) (Year) 5-13-1956			
5. SEX m		6. COLOR OR RACE w		7. MARRIED, NEVER MARRIED, 9 WIDOWED, DIVORCED (Specify) widow		8. DATE OF BIRTH 6-21-1868		9. AGE (In years last birthday) 87 yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) ret. Public Service Employee		10b. KIND OF BUSINESS OR INDUSTRY Michigan		11. BIRTHPLACE (City and State or Foreign Country) Michigan		12. CITIZEN OF WHAT COUNTRY? USA				
13a. FATHER'S NAME Theros Healy			13b. MOTHER'S MAIDEN NAME Matilda Bowersox			14. NAME OF HUSBAND OR WIFE Susan C. Healy				
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 James W. Healy					ADDRESS 5050 Union	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) chronic pulmonary TBC,				DUPLICATE TO (b) mod-advanced, active,				DUPLICATE TO (c) with emphysema & lungs.		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				II. OTHER SIGNIFICANT CONDITIONS						
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min)		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 5-1- , 19 56 , to 5-13- , 19 56 that I last saw the deceased alive on 5-13- , 19 56 and that death occurred at 10:50 A m. , from the causes and on the date stated above.										
23a. SIGNATURE (Degree or title) Bernard Friedman M.D.				23b. ADDRESS Koch Hosp, Koch mo.				23c. DATE SIGNED 5/13/56		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 5/16/56		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri				
DATE REC'D BY LOCAL REG. 5-15-56		REGISTRAR'S SIGNATURE Robert K. Ambrose			25. FUNERAL DIRECTOR'S SIGNATURE PROVOST UND. CO., 3710 No. Grand Bl.					

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 *Francis J. Weyland Jr.*.....

Licensed Embalmer No. *451*.....

P. O. Address *St. Louis, 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.