

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25266

STATE FILE NUMBER

FILED JUL 20 1956

318

1003

6291

Registration District No. Primary Registration District No. Registrar's No.

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| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) INSTITUTION <u>City Hospital</u> | | Length of stay in lb <u>25yrs.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Anna Belle Statler</u> First Middle Last | | 4. DATE OF DEATH <u>July 4, 1956</u> Month Day Year | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1 Aug 1898</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) <u>57</u> IF UNDER 1 YEAR: Months Days Hours Min. |
| 11. BIRTHPLACE (City and state or country) <u>Texas</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.</u> | |
| 13. FATHER'S NAME <u>George Crouch</u> | | 14. MOTHER'S MAIDEN NAME <u>Ida Paris</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unk.</u> | | 16. SOCIAL SECURITY NO. <u>489-26-7236</u> | 17. INFORMANT <u>Patient Record</u> Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> DUE TO (b) <u>Pulmonary fibrosis</u> DUE TO (c) <u>Congestive heart failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>434.1</u> | |
| 20c. TIME OF INJURY. Hour Month, Day, Year a. m. p. m. | | 20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from <u>6-27-56</u> to <u>7-4-56</u> and last saw her alive on <u>7-4-56</u> Death occurred at <u>City Hosp. 1:55 p m</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>John Albert Bunell M.D.</u> | | 22b. ADDRESS <u>1515 Lafayette</u> | |
| 22c. DATE SIGNED <u>Jul. 4, '56</u> | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>7/5/56</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Piggott Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Piggott, Arkansas</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>John H. Gebken Sons 2630 Gravois Ave.</u> | | 25. DATE RECD. BY LOCAL REG. <u>JUL 5 1956</u> | 26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u> |

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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 embalmed
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Robert F. Gebken*

Licensed Embalmer No. ⁴⁷⁴⁴.....

P. O. Address 2630 Gravois.....

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.