

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25438

FILED AUG 14 1956

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 1815

300
1-56

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

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>KIRKWOOD</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>KIRKWOOD</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST-JOSEPH'S HOS</u>			Length of stay in 1b <u>40YRS -</u>		d. STREET ADDRESS (If outside, give location) <u>920 QUANAH DR -</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>BEULAH</u> Middle <u></u> Last <u>COOK</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>28</u> Year <u>1956</u>					
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>AUG-10, 1884</u>		9. AGE (In years last birthday) <u>71</u> IF UNDER 1 YEAR: Months <u></u> Days <u></u> IF UNDER 24 HRS.: Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and state or country) <u>CALHOUN COUNTY, ILL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-S-A -</u>		
13. FATHER'S NAME <u>JOHN FOLLES</u>				14. MOTHER'S MAIDEN NAME <u>JULIA CLOVINGER</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO - NONE</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>HAROLD FOLLES EAST MOLINE, ILL.</u>				
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>Cerebral thrombosis</u> Conditions, if any, which gave rise to, above cause (a), stating the underlying cause last. DUE TO (b) <u>II Lobar pneumonia</u> DUE TO (c) <u>Arterio sclerotic heart disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>(?)</u> <u>5-10 years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4200</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
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.)			
20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>6/18/56</u> to <u>7/28/56</u> and last saw her <u>alive</u> on <u>7/27/56</u> Death occurred at <u>9:20 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Inscribed or title) <u>Heather M. Stevens MD</u>				22b. ADDRESS <u>Kirkwood (22) Mo</u>			22c. DATE SIGNED <u>7/28/56</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>7/29/56</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SUMMIT GROVE CEM - KAMPSVILLE, ILL</u>			23d. LOCATION (City, town, or county) (State) <u>ILL</u>		
24. FUNERAL DIRECTOR <u>PFITZINGER MORTUARY</u>			ADDRESS <u>KIRKWOOD MD.</u>		25. DATE RECD. BY LOCAL REG. <u>7-29-56</u>		26. REGISTRAR'S SIGNATURE <u>Heather M. Stevens MD</u>		

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 *William H. Peterson*.....
Licensed Embalmer No. *431*

P. O. Address *Wula*.....

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.