

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 24 1956

318

1003

28478

STATE FILE NUMBER

6766

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i> 9 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. Louis City Hospital</i>		Length of stay in lb	d. STREET ADDRESS <i>4622 Blvd</i> (If outside give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <i>Maude</i> First <i>Maude</i> Middle <i>Hamilton</i> Last	4. DATE OF DEATH <i>July 18, 1956</i> Month <i>July</i> Day <i>18</i> Year <i>1956</i>
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5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 19, 1872</i>	9. AGE (In years last birthday) <i>84</i>	IF UNDER 1 YEAR Months <i>1</i> Days <i>29</i>	IF UNDER 24 HRS. Hours <i>1</i> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTH PLACE (City and state or country) <i>Elkin, Ill.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13. FATHER'S NAME <i>Geo. Stevens</i>	14. MOTHER'S MAIDEN NAME <i>UNK.</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>George Bill</i> Address <i>5028^a Queens</i>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 Days</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		<i>465+</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Thrombosis of left middle cerebral artery</i>		

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.)
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20c. TIME OF INJURY Hour <i>4:45</i> Month <i>7</i> Day <i>13</i> Year <i>56</i> a. m. p. m.	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 <i>St. Louis</i>	COUNTY	STATE
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21. I attended the deceased from <i>7-13-56</i> to <i>7-18-56</i> and last saw her ^{born} alive on <i>7-18-56</i> Death occurred at <i>4:45a</i> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>LeRoy F. Ottewill M. D.</i>	22b. ADDRESS <i>1515 Lafayette</i>	22c. DATE SIGNED <i>7-19-56</i>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>7-21-56</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Friedens</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis Mo.</i>
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24. GENERAL DIRECTOR <i>Probst</i> ADDRESS <i>3710 N Grand</i>	25. DATE RECD. BY LOCAL REG. <i>JUL 19 1956</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith Mo</i> <i>m 976</i>
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(Licensed Embalmer's Statement on Reverse Side)

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 casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Gustav W. Deiter*

Licensed Embalmer No. *43*

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.