

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29010

FILED SEP 6 1956 Registration District No. **318** Primary Registration District No. **1003** STATE FILE NUMBER **7491** Registrar's No.

| | | | | | | | | | |
|---|----------------------------------|---|--|---|--|--|---|---|--|
| 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 <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME (If outside corporate limits, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1 | | | Length of stay in lb | | d. STREET (If outside, give location) ADDRESS 447 North Sarah St. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First BESSIE Middle MARIE R- Last RAMEY | | | | 4. DATE OF DEATH Month Aug Day 11 Year 1956 | | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Jan 20, 1908 | | 9. AGE (In years last birthday) 48 | | IF OVER 1 YEAR Months Days 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) Mt. Hope, West Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME John Kincaid | | | | 14. MOTHER'S MAIDEN NAME Louvinie Ward | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil | | | 16. SOCIAL SECURITY NO. 494-26-6388 | | 17. INFORMANT Frank Ramey, 447 North Sarah St. | | | 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) Pulmonary edema Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) renal failure DUE TO (c) Laennec's cirrhosis of liver | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 days unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.) 581.1 | | | | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. | | | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT <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 7-9-56 to 8-10-56 and last saw her alive on 8-10-56 Death occurred at 1:45 a.m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 21a. SIGNATURE (Degree or title) Jean O. Chapman, M.D. | | | | 21b. ADDRESS St. Louis City Hospital | | | 21c. DATE SIGNED 8-11-56 | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE 8-12-56 | 22c. NAME OF CEMETERY OR CREMATORY Local Cemetery | | 22d. LOCATION (City, town, or county) Mt. Hope, West Virginia | | (State) | | |
| 24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington | | | | 25. DATE RECD. BY LOCAL REG. AUG 13 1956 | | 26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.P. | | | |

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. 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

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YOUNG -- DEPT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em
by me, or by Student Embalmer No.
working under my personal supervision..

Student
Signature of Student Embalmer

Signed
John J. Haines
Licensed Embalmer No. *41*

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.