

FILED SEP 5 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29449

BIRTH NO. _____ REG. DIST. NO. 312 PRIMARY REG. DIST. NO. 572 Registrar's No. 1941

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 (If outside corporate limits, write RURAL and give township) OR TOWN Webster Groves		c. CITY OR TOWN Webster Groves d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (in this place) 6 Yrs		STREET ADDRESS (If rural, give location) 1001 East Big Bend Rd.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Bethesda Dilworth Home			
3. NAME OF DECEASED (Type or Print) a. (First) ADA b. (Middle) LOUISE c. (Last) CHAFFEE			4. DATE OF DEATH (Month) (Day) (Year) 8-13-1956
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 11-23-1858
9. AGE (In years last birthday) 97		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 Foreign Country) Sweden		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Clifton E Chaffee		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -----	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Roy O Chaffee 6107 Westminster	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES DUE TO (b) left DUE TO (c) Arteriosclerotic Vascular Disease II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. chr.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 331X	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE (Specify)	
21a. 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) (m.)		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 <u>June</u> , 1956, to <u>Aug 13</u> , 1956, that I last saw the deceased alive on <u>Aug 13</u> , 1956, and that death occurred at <u>4:30 p.</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) O Deabaugh M.D.		23b. ADDRESS Webster Groves Mo	
23c. DATE SIGNED Aug 14 1956		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 8-15-1956		24c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	
24d. LOCATION (City, town, or county) (State) Kirkwood Mo.		DATE REC'D BY LOCAL REG. 8-14-56	
REGISTRAR'S SIGNATURE Herbert R. Domb		FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wesker-aldrich - Webster Groves Mo.	

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

400
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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..... *Lucie Welch*

Licensed Embalmer No. *439*

P. O. Address *Wester Gro*

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.