

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 26 1956

32004

STATE FILE NUMBER

318

1003

8220

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 <u>MISSOURI</u> COUNTY		
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) HOSPITAL OR INSTITUTION <u>St. Louis City Hospital #1</u>		Length of stay in lb <u>50 YRS. 9 25 8</u>	d. STREET ADDRESS (If outside, give location) <u>1604 B. CASS-AV.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>M.</u> Last <u>Driemeyer</u>			4. DATE OF DEATH Month <u>September</u> Day <u>2</u> Year <u>1956</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 11TH 1890</u>	9. AGE (In years last birthday) <u>65 YRS.</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHELLING - PECAN-NUTS - FUNSTEN-NUT-CO.</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>GRAND-ISLAND - NEBRASKA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>UNKNOWN</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NONE</u>		16. SOCIAL SECURITY NO. <u>496-18-2751</u>	17. INFORMANT Address <u>JOHN-DRIEMEYER-1604 B CASS-AV.</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>Acute Renal Failure</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Shock</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) <u>Carcinomatosis from Uterine Carcinoma</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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>174X</u>			
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>8-31-56</u> to <u>9-2-56</u> and last saw <u>DEK</u> <u>him</u> alive on <u>9-2-56</u> Death occurred at <u>8:50p</u> _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>John M. McCarty MD</u>			22b. ADDRESS <u>1515 Lafayette</u>		22c. DATE SIGNED <u>9-4-56</u>
23a. BURIAL (CREMATION, REMOVAL) (Specify) <u>BURIAL</u>	23b. DATE <u>SEPT. 6TH 1956</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY-CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Brockland Und. G. 1827-HOGAN-ST.</u>		25. DATE RECD. BY LOCAL REG. <u>SEP 5 1956</u>		26. REGISTRAR'S SIGNATURE <u>Paul Smith MO</u> <u>MSB</u>	

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 *John Binkley*.....

Licensed Embalmer No. *365*

P. O. Address *St Louis*

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.