

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35670

STATE FILE NUMBER

FILED NOV 16 1956

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9542

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>ST. LOUIS, MISSOURI</b>  |                                  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | c. CITY<br>OR<br>TOWN <b>St Louis</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>              |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL #1.</b>  |                                  |   | Length of stay in lb  | d. STREET ADDRESS (If outside, give location) <b>2328 Virginia</b>                     |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>BLANCHARD</b> Middle Last <b>HUMPHREYS</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>OCT. 17,</b> Day <b>1956</b>   |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Mar 9 1882</b>   | 9. AGE (In years last birthday) <b>74</b><br>IF UNDER 1 YEAR<br>Months Days Hours Min. |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Owner</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Recreation Parlor</b>   |   | 11. BIRTHPLACE (City and state or country)<br><b>St Louis Mo</b>                       |   |
| 13. FATHER'S NAME<br><b>Robert Humphreys</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Jane Shaw</b>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |   | 17. INFORMANT Address<br><b>Marie Burkhardt Humphrey 2328 Virginia</b>                 |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Heart Failure</b><br>DUE TO (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO (c)<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |                                  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| 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?<br>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.)<br><b>420.0</b>  |   |  |   |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>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 COUNTY STATE  |   |
| 21. I attended the deceased from <b>10/15/56</b> to <b>10/17/56</b> and last saw her alive on <b>10/17/56</b><br>Death occurred at <b>12:05 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.   |                                  |   |   |  |   |
| 22a. SIGNATURE (Degree or title)<br><b>Charles E. Hogansamp, M.D.</b>   |                                  |   | 22b. ADDRESS<br><b>1515 LAFAYETTE AVE.</b>  |  | 22c. DATE SIGNED<br><b>10/18/56.</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |                                  | 23b. DATE<br><b>Oct 20 56</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Memorial Park</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis Cty Mo</b>                          |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>E.J. Schnur 3125 Lafayette</b>   |                                  |   | 25. DATE RECD. BY LOCAL REG.<br><b>OCT 19 1956</b>  |  | 26. REGISTRAR'S SIGNATURE<br><b>Carl Smith Mo</b>   |

(Licensed Embalmer's Statement on Reverse Side)

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

MEDICAL CERTIFICATION

Health, Welfare, Police, Vice

00 56

**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 *Thomas R. Fenwick*

Licensed Embalmer No. *37*

P. O. Address *3125 7th*

**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.