

Health,  
Welfare  
Public  
Service

300  
1-56

See entry, 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.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36318

FILED NOV 16 1956

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9317**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Res. 4339 Olive</b>		Length of stay in lb <b>45yrs</b>	STREET ADDRESS (If outside, give location) <b>4339 Olive St</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>FRANCES</b> Middle <b>Honeur</b> Last <b>TRABUE</b>			4. DATE OF DEATH <b>Oct. 11, 1956</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 23, 1894</b>	9. AGE (In years last birthday) <b>62</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N.Y. Life Ins. Co.</b>	11. BIRTHPLACE (City and state or country) <b>Hydesburg, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Jones Trabue</b>			14. MOTHER'S MAIDEN NAME <b>Honeur Williamson</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Mrs Frances G. Stroud 6252 McPherson</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarct</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>hypertensive cardiovascular disease</b> DUE TO (c) <b>-420.1.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>7 years</b>
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.)			
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 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>19:30</b> to <b>10 Oct 1956</b> and last saw her/him alive on <b>10 Oct 1956</b> Death occurred at <b>1:00 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Joseph A. Noah, MD</b>			22b. ADDRESS <b>University Club Bldg.</b>		22c. DATE SIGNED <b>Oct 12, 1956</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>(Cremation)</b>	23b. DATE <b>Oct. 15, 1956</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Crematory</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co, Missouri</b>		
24. FUNERAL DIRECTOR <b>Alexander &amp; Sons, Inc. 6175 Delmar Bl.</b>		25. DATE RECD. BY LOCAL REG. <b>OCT 13 1956</b>	26. REGISTRAR'S SIGNATURE <b>J Earl Smith MD</b>		

(Licensed Embalmer's Statement on Reverse Side)

1051C

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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 em  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *J. S. McCulloch*

Licensed Embalmer No. *24*

P. O. Address *6175*

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.