

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40787
STATE FILE NUMBER

FILED JAN 2 1957

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 341

300
-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with no reason. 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

1. PLACE OF DEATH a. COUNTY CALLAWAY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN FULTON		c. CITY OR TOWN LAKWOOD	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION STATE HOSPITAL #1		d. STREET ADDRESS 7911 JOY	
3. NAME OF DECEASED (Type or print) First ROSE Middle STOHL Last		4. DATE OF DEATH Month DEC. Day 25 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/19/82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (City and state or country) ST. LOUIS, MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES WHITMORE		14. MOTHER'S MAIDEN NAME MARY SWEENEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT STATE HOSPITAL #1, FULTON, MISSOURI		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) CORONARY OCCLUSION			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 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.)	
20c. TIME OF INJURY Hour _____ 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. STATE HOSPITAL #1 MAY 24, 1938, to DEC. 25, 1956 and last saw him alive on _____ Death occurred at 3:05 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE T. D. MC CARTHY, M.D.		22b. ADDRESS STATE HOSPITAL #1, FULTON, MO.	
22c. DATE SIGNED 12-27-56			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec-31-1956	
23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem		23d. LOCATION (City, town, or county) (State) St. Louis Mo	
24. FUNERAL DIRECTOR Hallace Funeral Home, Fulton, Mo		25. DATE RECD. BY LOCAL REG. Dec 27, 1956	
25. REGISTRAR'S SIGNATURE Maretha Lawrence			

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 *Donald C. Browning*

Licensed Embalmer No. *27*

P. O. Address *Fulton*

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.