

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. 44406

FILED JAN 15 1957

BIRTH NO. _____ REG. DIST. NO. 312 PRIMARY REG. DIST. NO. 500 Registrar's No. 3025

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
a. COUNTY <u>St. Louis</u>	b. CITY (If outside corporate limits, write RURAL and give township) <u>Gardenville</u>	a. STATE <u>Missouri</u>	b. COUNTY <u>St. Louis</u>
c. LENGTH OF STAY (in this place) <u>11 Months</u>		c. CITY OR TOWN <u>Ashton</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Miller Nursing Home</u>		e. STREET ADDRESS <u>Schuessler Road</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>ANNA</u>	b. (Middle) <u>ISABELL</u>	c. (Last) <u>UPSHAW</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>12-27-1956</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>6-22-1870</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>James Barton</u>	13b. MOTHER'S MAIDEN NAME <u>Cynthia Parker</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. A. D. Leisner</u>	ADDRESS <u>Schuessler Road</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3-5 yrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac failure</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic myocardial insufficiency</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>4/222</u>
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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?
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22. I hereby certify that I attended the deceased from Feb, 1956 to 12-27, 1956, that I last saw the deceased alive on 12-26, 1956, and that death occurred at 1:40 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>R. H. Schmeeman</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>6817 Gravois</u>	23c. DATE SIGNED <u>12/28/56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>12-29-1956</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>1215 Lemay Ferry Road Mo</u>
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DATE REC'D BY LOCAL REG. <u>12-28-56</u>	REGISTRAR'S SIGNATURE <u>Harriet B. Donahoe</u>	FUNERAL DIRECTOR'S SIGNATURE <u>R. H. Schmeeman</u>	ADDRESS <u>Box 6409 Gravois Ave</u>
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(Licensed Embalmer's Statement or Reverse Side)

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

FL 2-5034

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.....
Licensed Embalmer No. 434
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.