

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3612**
648

FILED FEB 4 1957

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____				
b. CITY OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (in this place) 3 Wks.		c. CITY OR TOWN St. Louis 4		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION Bethesda General Hospital 2171e				e. STREET ADDRESS (If rural, give location) 3224 St. Vincent				
3. NAME OF DECEASED a. (First) Matilda			b. (Middle) _____		c. (Last) Chisenhall		4. DATE OF DEATH (Month) (Day) (Year) January 19 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W		8. DATE OF BIRTH June 11 1867		9. AGE (In years last birthday) 89	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME John Lynch			13b. MOTHER'S MAIDEN NAME Fannie Stevenson		14. NAME OF HUSBAND OR WIFE William (Deceased)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME John Chisenhall, son.				ADDRESS 410 DeBalivere
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, asthma, etc. It means the disease, injury, or complication which caused death.								
MEDICAL CERTIFICATION								
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1 Broncho-Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 24 hrs						
ANTECEDENT CAUSES		DUE TO (b) 2 Mesenteric Thrombosis				INTERVAL 36 hrs		
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) Arteriosclerosis						
		DUE TO (c) Gangrene of left foot				3 Weeks		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Myocarditis 45.0.1								
19a. DATE OF OPERATION Jan 16 1957		19b. MAJOR FINDINGS OF OPERATION Gangrene of left foot - mid thigh amputation				20. AUTOPSY? 1 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
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) _____				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from 12-30-1956 , to 1-19-57 , 1957, that I last saw the deceased alive on 1-19- , 1957, and that death occurred at 4:40 P.M. , from the causes and on the date stated above.								
23a. SIGNATURE John W. Stewart (Degree or title) MD				23b. ADDRESS 4660 Maryland		23c. DATE SIGNED 1-19-57		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 1-22-1957		24c. NAME OF CEMETERY OR CREMATORY Tiedeman Cemetery		24d. LOCATION (City, town, or county) (State) O'Fallon, Illinois		
DATE REC'D BY LOCAL REG. JAN 21 '57		REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE McLAUGHLIN'S ADDRESS 2301 LAFZYTE AVE.				

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

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 *L. P. Cooper*.....

Licensed Embalmer No. *3633*

P. O. Address *2311 Jay*

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.