FILED FEB 6 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

2651 STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 269

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital — Length of stay in 1b: 4 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN Brentwood — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS 8500 Joseph Ave (If outside, give location) — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Lettie Middle A. Last Day

4. DATE OF DEATH Month Jan. Day 9th Year 1957

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH June 12th 1886

9. AGE (In years last birthday) 70 — 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 At Home

11. BIRTHPLACE (City and state or country) Monticella, Mo.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John L. Mackey

14. MOTHER'S MAIDEN NAME Lucinda Bailey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. None

17. INFORMANT Charles Day, Address Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular accident
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) arteriosclerosis of cerebral vessels.
DUE TO (c)

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) Essential Hypertension 331.X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 1-6-57, to 1-9-57 and last saw her/him alive on 1-9-57. Death occurred at 10:30 pm m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Ernest H. Schaper (Degree or title) M.D.

22b. ADDRESS 7200 Manchester

22c. DATE SIGNED 1-10-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 1-11-57

23c. NAME OF CEMETERY OR CREMATORY Monticella Cemetery

23d. LOCATION (City, town, or county) Monticella, Mo (State)

24. FUNERAL DIRECTOR JAY B. SMITH ADDRESS Maplewood, Mo.

25. DATE RECD. BY LOCAL REG. JAN 10 '57

26. REGISTRAR'S SIGNATURE J. Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address .....

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.