

Health, Welfare and Public Service  
 300  
 1-56  
 All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED FEB 26 1957

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

6526

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1377**

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>4737 a Alaska ave.</b>			Length of stay in 1b	d. STREET ADDRESS <b>4737 a Alaska ave.</b>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>First Middle Last</i> <b>Shirley G. Pidgeon</b>				4. DATE OF DEATH <i>Month Day Year</i> <b>February 10, 1957</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 28, 1934</b>		9. AGE (In years last birthday) <b>22</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>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Walter Plage</b>				14. MOTHER'S MAIDEN NAME <b>Clara Baskett</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. ---		17. INFORMANT <b>Francis Pidgeon</b> Address <b>4737a Alaska ave.</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>Cerebral Embolus.</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Rheumatic Heart Disease</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) <b>416x</b>							INTERVAL BETWEEN ONSET AND DEATH <b>7 1/2</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 a. m. p. m. Month, Day, Year								
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>Oct 1956</b> to <b>Feb 1957</b> and last saw her alive on <b>2-8-57</b> Death occurred at <b>10A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>John J. O'Leary M.D.</b>				22b. ADDRESS <b>5203 Chesapeake</b>		22c. DATE SIGNED <b>2-11-57</b>		
23a. BURIAL, CREMATION, REMOVAL, or SPECIAL		23b. DATE <b>Feb. 13, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Trinity Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>2000 Lemay Ferry Rd. Lemay, Mo.</b>			
24. FUNERAL DIRECTOR <b>C. Hoffmeister Mortuaries</b> 7814 S. Broadway				25. DATE RECD. BY LOCAL REG. <b>FEB 11 '57</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b> -m.d.s		

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1-3300m

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 *Louis C. Hoffmann*

Licensed Embalmer No. 38

P. O. Address 7814

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.