

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6850

STATE FILE NUMBER

0832 *at plus Rd*
FILED FEB 25 1957
Whitener

Registration District No. *317* Primary Registration District No. *541* Registrar's No. *275*

1. PLACE OF DEATH a. COUNTY <i>ST LOUIS</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MISSOURI</i> b. COUNTY <i>ST LOUIS</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>CLAYTON</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <i>BREGENRIDGE HILLS</i> <i>4/231</i>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>ST LOUIS CO</i>		Length of stay in 1b <i>D.O.A.</i>	d. STREET ADDRESS (If outside, give location) <i>3101 CALVERT</i>
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <i>THOMAS</i> <i>MALCOM</i> <i>HOUSER</i>			4. DATE OF DEATH <i>1-29-57</i>		
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-28-1939</i>	9. AGE (In years last birthday) <i>17</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>	11. BIRTHPLACE (City, and state or country) <i>ST LOUIS CO MO</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>THOMAS W HOUSER</i>			14. MOTHER'S MAIDEN NAME <i>RUTH SPAULDING</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT <i>THOMAS W. HOUSER</i> Address <i>3101 CALVERT</i>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal Pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 da.</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Muscular dystrophy</i>		<i>15 years</i>
	DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Almost complete loss of muscular system 7441</i>		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 <i>.....</i> Month <i>.....</i> Day <i>.....</i> Year <i>.....</i> a. m. <i>.....</i> p. m. <i>.....</i>		
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 <i>several years</i> to <i>26 Jan 1957</i> and last saw <i>her</i> <i>him</i> alive on <i>Dec 1956</i> Death occurred at <i>As</i> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <i>Paul H. Whitener</i> (Degree or title) <i>M.D.</i>	22b. ADDRESS <i>10832 St. Charles, Attn Mo.</i>	22c. DATE SIGNED <i>30 Jan 1957</i>

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Funeral</i>	23b. DATE <i>2-1-57</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Fee Fee Cem.</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis Co. Mo.</i>
24. FUNERAL DIRECTOR <i>EARL HILTMAN</i> ADDRESS <i>OVERLAND, MO.</i>	25. DATE RECD. BY LOCAL REG. <i>1-30-57</i>	26. REGISTRAR'S SIGNATURE <i>Herbert B. Dumble</i>	

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Director, coroner, etc. must use only standard nomenclature in item 18. No symptoms written on this certificate. Coroner cannot certify to a death due to natural causes. diseases in Part I must be casually related. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Carl S. Selman*.....

Licensed Embalmer No. *350*

P. O. Address *Deland*

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.