

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9912

FILED APR 12 1957

318

1003

STATE FILE NUMBER

2621

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

Health,
& Welfare
Public
Service

S. 300
1-56

securing the medical certification in the specific manner required by 193.140 MO. S. 300.1-56. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <u>42 INSTITUTION MARIAN HOSPITAL</u>			Length of stay in lb		d. STREET ADDRESS <u>20478 3558 LAWN AVE</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>OLIVE</u> Middle <u>L</u> Last <u>BENNETT</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>15</u> Year <u>1957</u>						
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 9 1885</u>		9. AGE (In years last birthday) <u>71</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (City and state or country) <u>GALVESTON TEXAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-S-A</u>			
13. FATHER'S NAME <u>EDWARD MARCUS BONE</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>						
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 Address <u>JOHN R BENNETT 3538 LAWN AVE</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary oedema</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Myocardial Insufficiency</u>		DUE TO (c) <u>Diabetes Mellitus</u>		6 mos		4 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary arteriosclerosis</u>							260x		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" 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 <u>June 10, 1957</u> to <u>3/15/57</u> and last saw her alive on <u>3/14/57</u> Death occurred at <u>10 45 A m</u> on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE <u>P. M. Greub M D</u> (Degree or title)				22b. ADDRESS <u>3402 California</u>			22c. DATE SIGNED <u>3/16/57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>MARCH-18-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MOUNT HOPE CEM.</u>			23d. LOCATION (City, town, or county) <u>ST. LOUIS</u>		23e. STATE <u>MO</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Thomas Kute 2906 Gravia</u>			25. DATE RECD. BY LOCAL REG. <u>MAR 18 '57</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>					

Pr 2-3860
3-5 Saturday

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.....
James C Hill

Licensed Embalmer No. 4347

P. O. Address 2906 ...

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.