

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 12 1957

STATE FILE NUMBER

10198

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2468**

Health, Welfare Public Service

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 casually 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 <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>DE PAUL HOSPITAL</b>		Length of stay in lb <b>20 yrs. 2 2/3</b>		d. STREET ADDRESS <b>2304a Russell Ave.</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RACHEL</b> Middle <b>P.</b> Last <b>EDEN</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>10</b> Year <b>1957.</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 1, 1904.</b>	9. AGE (In years last birthday) <b>52</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TELEPHONE OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TELEPHONE CO.</b>		11. BIRTHPLACE (City and state or country) <b>PIERCE CITY, MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PHILLIP JOCHUM</b>				14. MOTHER'S MAIDEN NAME <b>ROSE SPEAKS</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 Address <b>MRS. A. P. HEIL, 2304a Russell 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>Acute Myelocytic Leukemia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 Mo</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (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>204:2</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 Month, Day, Year a. m. p. m.							
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>5-10-56</b> to <b>3-10-57</b> and last saw her <sup>her</sup> <sub>born</sub> alive on <b>3-10-57</b> Death occurred at <b>11:40 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Sunny A. Reel, M.D.</i>				22b. ADDRESS <b>5633 Kings Highway</b>		22c. DATE SIGNED <b>3/12/57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>3/14/57.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SUNSET BURIAL PARK</b>		23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS COUNTY, MO.</b>		
24. FUNERAL DIRECTOR <b>CALVIN F. FEUTZ FUNERAL HOME, INC.</b> 4828 Natural Bridge Blvd. St. Louis, Mo.				25. DATE RECD. BY LOCAL REG. <b>MAR 12 '57</b>		26. REGISTRAR'S SIGNATURE <i>J. Earl Smith, M.D.</i> S.O.	

(Licensed Embalmer's Statement on Reverse Side)

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 *John A. M...* .....  
Licensed Embalmer No. 418

P. O. Address *St. Louis*

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.