Health, Welfare Public Service

5

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

FILED MAR 27 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

10350

STATE FILE NUMBER 1003

Registration District No. 318 Primary Registration District No. Registrar's No. 2382

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS Mo — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 01 2031a ALLEN — Length of stay in 1b 2 239

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN ST. LOUIS — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 2031a ALLEN — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First MARY Middle Last HADDOCK.

4. DATE OF DEATH Month MAR. Day 8 Year 1957

5. SEX Female

6. COLOR OR RACE WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ 2 DIVORCED ☐

8. DATE OF BIRTH AUG. 15 1876

9. AGE (In years last birthday) 80 — 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) WIDOW

10b. KIND OF BUSINESS OR INDUSTRY AT Home

11. BIRTHPLACE (City and state or country) ILLINOIS 1

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME MICHAEL WALSH

14. MOTHER'S MAIDEN NAME MARY GREGORY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. None

17. INFORMANT JOSEPH P. HADDOCK Address 2031a ALLEN

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) LOBAR PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH 4 DAYS.

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) 490X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑ 2

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 MARCH. 4-57, to March 8-57 and last saw her/him alive on 3-8-57
Death occurred at 10 45 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Wm R. Gum MD

22b. ADDRESS 2227 S Broadway

22c. DATE SIGNED 3-9-57

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

23b. DATE MAR. 11 1957

23c. NAME OF CEMETERY OR CREMATORY CALVARY CEM.

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

24. FUNERAL DIRECTOR Thomas Kutis ADDRESS 2906 Gravois

25. DATE RECD. BY LOCAL REG. MAR 11 '57

26. REGISTRAR'S SIGNATURE J. Earl Smith M.D. M.J.B.

(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 emb

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

working under my personal supervision..

Student ..... Signature of Student Embalmer

Signed James C Dill

Licensed Embalmer No. 434

P. O. Address 2906 St

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
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.