

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10455

FILED MAR 18 1957

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1749**

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 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 Illinois b. COUNTY Madison	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN Wood River 812-8	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Length of stay in 1b 12 days	d. STREET ADDRESS (If outside, give location) 32 309 Madison
3. NAME OF DECEASED (Type or print) First LUVA Middle ODESSA Last HUGHART		4. DATE OF DEATH Month FEB. Day 19, Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29, 1925
9. AGE (In years last birthday) 31		IF UNDER 1 YEAR Months 31 Days 31 Hours 31 Min. 31	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Mozier, Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Leroy Watts	
14. MOTHER'S MAIDEN NAME Mary Fox		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 488-24-8600		17. INFORMANT Address Richard Hughart, Wood River, Ill.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation			INTERVAL BETWEEN ONSET AND DEATH 20 YRS.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Aortic Stenosis & Mitral Stenosis			
DUE TO (c) Rheumatic Heart Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)			
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 12-15 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 FEB. 7, 1957 to FEB. 19, 1957 and last saw ^{her} him alive on FEB. 19, 1957 Death occurred at 12-15 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Carl Smith M.D.</i> (Degree or title)		22b. ADDRESS M. D., BARNES HOSPITAL	
22c. DATE SIGNED 2/19/57		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE 2-20-57		23c. NAME OF CEMETERY OR CREMATORY Woodland Hill Cemetery	
23d. LOCATION (City, town, or county) (State) Wood River, Ill.		24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd.	
25. DATE RECD. BY LOCAL REG. FEB 20 '57		26. REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>	

Richard H. Hobbie, 100 Washington Blvd.
 No. 11111
 15 days
 Hobbie
 1922
 At Home
 Housewife
 Female
 White
 No. 11111

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 Signed *Elmer R. Caldwell*
 Signature of Student Embalmer
 Licensed Embalmer No. *407*
 P. O. Address *St Louis*

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