

FILED APR 15 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11880

STATE FILE NUMBER 2967

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 01 5479 Beacon Ave.		Length of stay in lb 2079	
d. STREET ADDRESS 5479 Beacon Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MRS. RUTH SHOULTS			4. DATE OF DEATH Month Mar Day 26 Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 30. 1887
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Wood	
14. MOTHER'S MAIDEN NAME Martha Meade		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. None.		17. INFORMANT Address George Rogers, son-in-law. 5479 Beacon Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Sclerosis DUE TO (c) Chance.			INTERVAL BETWEEN ONSET AND DEATH 4 da
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331x			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
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 July 15 to 56 3/26/57 and last saw her alive on 3-26/57 Death occurred at 7:40 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE J. D. Peeler M.D. (Degree or title)		22b. ADDRESS 2503 No. T. Lawrence	22c. DATE SIGNED 3-27-57
23a. BURIAL, CREATION, REMOVAL (Specify) Removal	23b. DATE Mar. 29. 57	23c. NAME OF CEMETERY OR CREMATORY Flatwood Cemetery	23d. LOCATION (City, town, or county) (State) Eminence Mo.
24. FUNERAL DIRECTOR Henry Leidner Und. Co ADDRESS 2223 St. Louis Ave.		25. DATE RECD. BY LOCAL REG. MAR 27 '57	26. REGISTRAR'S SIGNATURE J. Earl Smith M.D. S/P

(Licensed Embalmer's Statement on Reverse Side)

Health,
& Welfare
Public
Service300
1-56

securing the medical certification in the specific manner required by the laws of Missouri.
 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

200

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 *Stanley H. Dixon*

Licensed Embalmer No. *419*

P. O. Address *St. L.*

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.