

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11094

STATE FILE NUMBER

FILED APR 15 1957

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2994

Health & Welfare
Public Health Service

300
1-56

securing the medical certification in the specific manner required by 193.140 MoRS 1949.
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 Missouri b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION 14 Jewish Hospital			Length of stay in hospital 1 day. 2057	d. STREET ADDRESS 5611 Enright Ave, Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CORA Middle LUCRETIA Last SKELTON.			4. DATE OF DEATH Month Day Year March 26, 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 Dec 28, 1876.	9. AGE (In years to birthday) 80. IF UNDER 1 YEAR Months Days Hours Min.	
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) Aurora, Nebraska.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME UNKNOWN Wilcoxen.			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) no.		16. SOCIAL SECURITY NO. UNK	17. INFORMANT Address Max Skelton #5611 Enright 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) Myocardial infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary sclerosis DUE TO (c) 420.1					INTERVAL BETWEEN ONSET AND DEATH 1 1/2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					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		STATE
21. I attended the deceased from 1947 to Mar 26 1957 and last saw her alive on Mar 26 57 Death occurred at 4:35 p m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Barrett L Tausig MD.			22b. ADDRESS 4500 Oliv St. St Louis 8		22c. DATE SIGNED Mar 27 57
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE Mch 28/57.	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory.		23d. LOCATION (City, town, or county) (State) #7800 St. Charles Road.	
24. FUNERAL DIRECTOR ADDRESS C. R. Lupton & Sons. 7233 Delmar Blvd. m			25. DATE RECD. BY LOCAL REG. MAR 28 57	26. REGISTRAR'S SIGNATURE J. Carl Smith, MD 2076	

January

4500 Olive

Mo. 7-3806

Mo. 7-3806

HOME PHONE - 441-1143

WILL BE HOME AFTER 6:00 PM.

18 MARKHAMSETT, R.S.

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 *Arnold W. Schoene*

Licensed Embalmer No. *3865*

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.