

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11582**

FILED MAR 29 1957

BIRTH NO. _____ REG. DIST. NO. **517** PRIMARY REG. DIST. NO. **590** Registrar's No. **743**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Brentwood 400		c. LENGTH OF STAY (in this place) 6 Years	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2807 Lawndell Dr.		e. STREET ADDRESS (If rural, give location) 2807 Lawndell Dr.	

3. NAME OF DECEASED (Type or Print) a. (First) Cecelia	b. (Middle)	c. (Last) Kammer	4. DATE OF DEATH (Month) (Day) (Year) March 17, 1957
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb. 1, 1876	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS. Days 16	IF UNDER 1 MIN. Hours	12. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (City and State or Foreign Country) Warrenton, Missouri				

13a. FATHER'S NAME Michael McShane	13b. MOTHER'S MAIDEN NAME Catherine Oregon	14. NAME OF HUSBAND OR WIFE Nickolas
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Bird McShane	ADDRESS 2807 Lawndell Dr.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, athermia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4-6 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) C. V. A.		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) My father since Cardiovascular disease DUE TO (c) none		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **9-16**, 19**53** to **3-17**, 19**57**, that I last saw the deceased alive on **3-17**, 19**57**, and that death occurred at **11:00 AM** from the causes and on the date stated above.

23a. SIGNATURE E. McCall MD (Degree or title)	23b. ADDRESS Brentwood Mo	23c. DATE SIGNED Mar 18 57
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24a. BURIAL, CREMATION REMOVAL (Specify) Removal	24b. DATE 3/21/57	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. 3-20-57	REGISTRAR'S SIGNATURE Heber R. Somke MD	25. FUNERAL DIRECTOR'S SIGNATURE Phas. F. Stuart	ADDRESS 1225 Union Bl.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Melvin L. Kemper*

Licensed Embalmer No. *405*

P. O. Address *3505 Oak*

St. Louis 20, Mo.

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.