

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **15003**  
Registrar's No. **3453**

FILED APR 26 1957

318

PRIMARY REG. DIST. NO. **1003**

REG. DIST. NO.

BIRTH NO.

REG. DIST. NO.

PRIMARY REG. DIST. NO.

REGISTRAR'S NO.

3453

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS Mo</b>		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN <b>ST. LOUIS</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>3801 WYOMING 2160</b>				STREET ADDRESS (If rural, give location) <b>3801 WYOMING</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>FLORENCE R.</b> b. (Middle) <b>McKINNIS</b> c. (Last) <b>McKINNIS</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>APRIL 9 1957</b>				
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>MAR. 28 1873</b>		9. AGE (In years) (last birthday) <b>84</b>	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) <b>WIDOW</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13a. FATHER'S NAME <b>MARCUS BRYANT</b>		13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		14. NAME OF HUSBAND OR WIFE			
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. <b>NONE</b>	17. INFORMANT'S SIGNATURE OR NAME <b>RUTH COBLE</b> ADDRESS <b>3801 WYOMING</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Paraplegia - left</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertension &amp; gen</b> DUE TO (c) <b>arteriosclerosis</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>None</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <b>2</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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)		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 <b>4/4/57</b> to <b>4/9/57</b> , that I last saw the deceased alive on <b>4/9/57</b> , and that death occurred at <b>5:20 a.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>W. F. Allen</b> (Degree or title) <b>MD</b>				23b. ADDRESS <b>5203 Chestnut</b>		23c. DATE SIGNED <b>4/10/57</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24b. DATE <b>APR. 11 1957</b>	24c. NAME OF CEMETERY OR CREMATORY <b>LAKEWOOD PARK</b>		24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS Mo</b>		
DATE REC'D BY LOCAL REG. <b>APR 10 57</b>		REGISTRAR'S SIGNATURE <b>Carl Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>W. Thomas Kutis</b> ADDRESS <b>2906 Travis</b>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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EV  
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**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 *Leif Budde*

Licensed Embalmer No. *3989*

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.