

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15420
STATE FILE NUMBER
3450

FILED APR 26 1957

318

1003

Registration District No. Primary Registration District No.

Registrar's

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.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input 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 lb 2 1/2	d. STREET ADDRESS 4910 W. Pine Forest Park Hotel (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First KATHLEEN Middle PORTER Last WALLACE			4. DATE OF DEATH Month APRIL Day 9 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 Oct. 5, 1890	9. AGE (In years last birthday) 66	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	11. BIRTHPLACE (City and state or country) Little Rock, Ark.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Tirrill			14. MOTHER'S MAIDEN NAME Lenora Cribbs		
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 Robert Brookings Wallace 4910 W. Pine Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA		INTERVAL BETWEEN ONSET AND DEATH 2-3 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) LAENNEC'S CIRRHOSIS (ALCOHOLIC)		1-2 YRS.
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS AND INACTIVE TUBERCULOSIS		19. WAS AUTOPSY PERFORMED? YES <input 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.) 5811A	
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 MARCH 25, 1957 to APRIL 9, 1957 and last saw her alive on APRIL 9, 1957 Death occurred at 9:35 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <i>C. D. McMillion, M.D.</i> (Degree or title)	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 4/9/57

23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 4-10-57	23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery	23d. LOCATION (City, town, or county) St. Louis, Missouri
24. FUNERAL DIRECTOR C.R. Lupton & Sons	ADDRESS 7233 Delmar Blvd.	25. DATE RECD. BY LOCAL REG. APR 10 '57	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith M.D.</i> mgs

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Service
S. 300
y. 1-56
securing the medical certification in the specific manner required by 193.140 MO RS 1947.
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

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. Schoen*

Licensed Embalmer No. *3864*

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.