

FILED APR 29 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15612

STATE FILE NUMBER

Registration District No. 317

Primary Registration District No. 544

Registrar's No. 901

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirkwood		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Webster Groves		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Scudder Nursing Home			Length of stay in 1b 1 yr.		d. STREET ADDRESS (If outside, give location) 601 Locksley Pl.			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First OLIVE Middle S Last STOVER				4. DATE OF DEATH Month 4 Day 3 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 Dec, 18, 1870		9. AGE (In years last birthday) 86		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) St. Joseph, Michigan		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George E. Smith				14. MOTHER'S MAIDEN NAME Isabel Chapman				
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 Mrs. E. H. Jacobsmeyer, 601 Locksley			
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.							Plac	INTERVAL BETWEEN ONSET AND DEATH 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Arteriosclerosis of Coronary Arteries		DUE TO (c)		Years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Encephalomalacia due to Arteriosclerosis.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) None					
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year	-----					
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.) None		20f. CITY, TOWN, OR LOCATION -----		COUNTY		STATE
21. I attended the deceased from May 14, 1956 to Apr. 3, 1957 and last saw him alive on Apr. 3, 1957 Death occurred at 8:00 P. m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) H. D. Goodrich				22b. ADDRESS 19 E. Lockwood Ave., Webster Groves 19, Mo.			22c. DATE SIGNED Apr. 5, 1957	
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation		23b. DATE 4-5-57	23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory		23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.			
24. FUNERAL DIRECTOR ADDRESS C. R. Lupton & Sons-7233 Delmar				25. DATE RECD. BY LOCAL REG. 4-5-57		26. REGISTRAR'S SIGNATURE Herbert B. Dombrowski		

(Licensed Embalmer's Statement on Reverse Side)

Health & Welfare
Public
ServiceS. 300
V. 56

securing the medical certification in the specific manner required by 193.140 WORKS 1957.
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

MEDICAL CERTIFICATION

89

W/O. 2-3200
8:00 To 9:30^{PM} FRIDAY

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. *386*

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.