THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

18840

STATE FILE NUMBER

FILED MAY 27 1957 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4551

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): ST. LOUIS CITY HOSP. #1. — Length of stay in 1b: 25 — 2
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri — b. COUNTY
c. CITY OR TOWN: St. Louis, — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 3628 California — Reside on Farm: Yes ☐ No ☒
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3. NAME OF DECEASED (Type or print): First DOVIE — Middle LEE — Last HUGHES
4. DATE OF DEATH: Month MAY — Day 13, — Year 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 15, 1889
9. AGE (In years last birthday): 67 — 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and state or country): St. Francis, Arkansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Tom Pentescott
14. MOTHER'S MAIDEN NAME: Clemie Orsburn
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. — (If yes, give war or dates of service): Nil.
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Tom Hughes, 2500 Semple, Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHOLELITHIASIS — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____ 584x
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 ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year
20d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 5/6/57, to 5/13/57 and last saw her/him alive on 5/13/57
Death occurred at 4:10 A.M m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): George E. Magaletta, MD.
22b. ADDRESS: 1515 LAFAYETTE AVE.
22c. DATE SIGNED: 5/13/57

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 5-13-57
23c. NAME OF CEMETERY OR CREMATORY: Gravel Hill Cemetery
23d. LOCATION (City, town, or county) (State): St. Francis, Arkansas

24. FUNERAL DIRECTOR — ADDRESS: Albert H. Hoppe 4700 Washington,
25. DATE RECD. BY LOCAL REG.: MAY 13 '57
26. REGISTRAR'S SIGNATURE: J Carl Smith MD MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or ~~by~~....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
(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.