

FILED JUL 1 1957

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH
57 0 2 2 0 7 9
STATE FILE NUMBER
 Registration District No. 317 Primary Registration District No. 543 Registrar's No. 1375

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>St. Louis</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jennings</u>		a. STATE <u>Mo.</u>		b. COUNTY <u>St. Louis</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>9425 Pickford Pl.</u>		Length of stay in lb <u>1 yr.</u>		c. CITY OR TOWN <u>Jennings</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <u>9425 Pickford Pl.</u>				(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>Blanche</u>		Middle <u>M.</u>		Last <u>Higgins</u>		Month <u>5</u> Day <u>29</u> Year <u>57</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 11, 1872</u>	
9. AGE (In years last birthday) <u>85</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Robinson, Ill.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Dallas DeLoppe</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Mrs. Hazel B. Malmberg</u> Address <u>9425 Pickford Pl.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE - (a) <u>CEREBRAL Vascular Accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>Arteriosclerosis</u>	
						DUE TO (c) <u> </u>	
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>	
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.) <u>331X</u>			
20c. TIME OF INJURY Hour <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> a. m. <u> </u> p. m. <u> </u>							
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 <u>May 7, 1957</u> to <u>5/29/57</u> and last saw her alive on <u>5/18/58</u> Death occurred at <u>2:30</u> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22. SIGNATURE (Degree or title) <u>Walter J. Kutnyk, M.D.</u>				22a. ADDRESS <u>6000 W. Flourent</u>		22c. DATE SIGNED <u>5/31/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>5/31/57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>	
24. FUNERAL DIRECTOR <u>Drehmann-Harral</u>		ADDRESS <u>1905 Union</u>		25. DATE RECD. BY LOCAL REG. <u>5-31-57</u>		26. REGISTRAR'S SIGNATURE <u>Hebecl R. Amke, M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 Coroner cannot certify to a death due to natural causes.

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Dr. Walter J. Kutryk
Missouri Pacific Hospital
1755 So. Grand

Hrs. 9:30 - 1 Fri.

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... *Albert R. Thompson*

Licensed Embalmer No. 43

P. O. Address *H. J. ...*

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.