

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

FILED JUL 3 1957

57-023148
State File No.

REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 1372

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>500</u>		Registrar's No. <u>1372</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis City</u>			
b. CITY OR TOWN <u>Koch, Mo.</u>		c. CITY OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>11 days</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>2179 03234 Copelin</u>			
3. NAME OF DECEASED (Type or Print) <u>William M. Christie</u>		a. (First)		b. (Middle)		4. DATE OF DEATH (Month) (Day) (Year) <u>5-28-57</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>7-1-98</u>	
9. AGE (In years last birthday) <u>58</u>		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) <u>Maintenance Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Famous Barr Co.</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Christie</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Naomi Christie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unk.</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Records Robert Koch Hosp. Koch, Mo.</u>			
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, athermia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>(?)</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? <u>2</u> 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) <u>002x</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 <u>5-17</u> , 19 <u>57</u> , to <u>5-28</u> , 1957, that I last saw the deceased alive on <u>5-28</u> , 19 <u>57</u> , and that death occurred at <u>9:40 AM</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>H.A. Harris</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>Koch Hospital, Koch, Mo</u>		23c. DATE SIGNED <u>5-28-57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5-31-1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>5-31-57</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Dombey</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>McLAUGHLIN F.H., Inc. 2301 Lafayette</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

Licensed Embalmer No.

P. O. Address.....

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.