

FILED JUL 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH26094
STATE FILE NUMBER
5676
REGISTRAR'S NO.

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH a. COUNTY				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 St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN University City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital			Length of stay in 1b		STREET ADDRESS 6900 Waterman		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN M FLEMING				4. DATE OF DEATH Month Day Year June 18-1957						
5. SEX Male		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. 3-1894		9. AGE (In years last birthday) 62 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor of Dental Surgery			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Poplar Bluff, Mo.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Ira Fleming				14. MOTHER'S MAIDEN NAME Martha Simpson						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) yes W.W.I			16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. J. M. Fleming 6900 Waterman			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) Myocardial Infarction Coronary Thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 1 day		
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.) 420-1						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 9-25-36 to 6-18-57 and last saw her alive on 6-18-57 Death occurred at 12:45 A. m. on the date stated above; and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE Carl J. Hines M.D.					22b. ADDRESS 18 S. Highway			22c. DATE SIGNED 6-18-57		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6-20-1957		23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.				
24. FUNERAL DIRECTOR C. R. Lupton & Sons 7233 Delmar				25. DATE RECD. BY LOCAL REG. JUN 18 '57		26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. 30p.				

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 10. No symptoms with 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

300
1-56

12:30-5

201-97 0116

20 2001-1100

of, first name

middle name

name

sex

age

height

weight

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 *C. Lawrence A. Murray*

Licensed Embalmer No. *401*

P. O. Address *St. Louis*

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.