

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26391
STATE FILE NUMBER
REGISTRAR'S NO. 6041

FILED JUL 26 1957

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 Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS 4228 Westminister	
3. NAME OF DECEASED (Type or print) DORA		4. DATE OF DEATH JUNE 27, 1957	
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) Marline, Mich.
13. FATHER'S NAME Wm R. Bailey		14. MOTHER'S MAIDEN NAME Claranda (unknown)	
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. Kracht, 4228 Westminister
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE CARDIOVASCULAR DISEASE 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 10 YRS.
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 443x	
20c. TIME OF INJURY Hour _____ 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 MAY 16, 1957 to MAY 24, 1957 and last saw her alive on MAY 24, 1957 Death occurred at 4:35 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>C. J. Vermillion, M.D.</i>		22b. ADDRESS BARNES HOSPITAL	
22c. DATE SIGNED 6/27/57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7/1/57	23c. NAME OF CEMETERY OR CREMATORY Memorial Park	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
24. FUNERAL DIRECTOR Robert D. Kinealy 2228 St. Louis Ave.		25. DATE RECD. BY LOCAL REG. JUN 28 '57	26. REGISTRAR'S SIGNATURE <i>Charles Smith</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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STATE OF MARYLAND

DEPARTMENT OF HEALTH

STATE OF MARYLAND

DEPARTMENT OF HEALTH

AND

STATE OF MARYLAND

STATE OF

DEPARTMENT OF HEALTH

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.....

X working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Harvey Kable*

Licensed Embalmer No. 459

P. O. Address *Flouissant*

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.