

FILED JUL 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26457

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5754**

Health, Welfare, Public Services
100
1-56
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will 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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY ST LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN RURAL - BONNOMME HI - 1414000	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) HI - 141	
3. NAME OF DECEASED (Type or print) First IDA Middle LOUISE Last PIERCE		4. DATE OF DEATH Month JUNE Day 18 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 1, 1897
9. AGE (In years last birthday) 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. BIRTHPLACE (City and state or country) ST. LOUIS CO., MO.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Wm. WISSMANN	
14. MOTHER'S MAIDEN NAME LOUISE ARFT		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT RUBY FINN, OVERLAND, MO	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningitis Conditions, if any, which gave rise to above cause (b), stating the underlying cause last. DUE TO (b) Disseminated Infection DUE TO (c) Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH 2 Days 3 Mos
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? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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.)	
20c. TIME OF INJURY Hour a. m. Month, Day, Year 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 17, 1957 to JUNE 18, 1957 and last saw ^{her} him alive on JUNE 18, 1957 Death occurred at 8:00 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) C. Vermillion, M.D.		22b. ADDRESS BARNES HOSPITAL	
22c. DATE SIGNED 6/19/57			
23a. BURIAL, CREMATION, or other (Specify) BURIAL	23b. DATE 6-21-57	23c. NAME OF CEMETERY OR CREMATORIAL Trinity Cem.	
23d. LOCATION (City, town, or county) Clayton + Woodsmiel Rds.		(State)	
24. FUNERAL DIRECTOR SCHRAEDER FUN. HOME, BALLWIN, MO		25. DATE RECD. BY LOCAL REG. JUN 20 '57	
ADDRESS		26. REGISTRAR'S SIGNATURE J. Carl Smith MD	

(Licensed Embalmer's Statement on Reverse Side)

S.P.

INDUSTRIAL DEPARTMENT
STATE OF CALIFORNIA

STATE OF CALIFORNIA PROFESSIONAL REGULATION ACT

STATEMENT BY LICENSED EMBALMER

NOTES: THIS CERTIFICATE IS VALID FOR ONE YEAR FROM THE DATE OF ISSUANCE.

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 *Richard Bopp*.....

Licensed Embalmer No. *45*

P. O. Address *Dallwin*

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.