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1-56

power attorney, etc., must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED AUG 1 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE OF MISSOURI
26610
REGISTRATION DISTRICT NO. 318
PRIMARY REGISTRATION DISTRICT NO. 1003
REGISTRAR'S NO. 6664

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>FLORISSANT 40011</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DE PAUL HOSPITAL</u>		Length of stay in 1b <u>1 WEEK</u>	d. STREET ADDRESS (If outside, give location) <u>740 CROWDER</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>RUTH</u> Last <u>STOKES</u>			4. DATE OF DEATH Month <u>JULY</u> Day <u>16</u> Year <u>1957</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 1 1914</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	9. AGE (In years last birthday) <u>43</u> IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <u>WAVERLY ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.B.</u>	
13. FATHER'S NAME <u>JOHN W SLAUGHTER</u>		14. MOTHER'S MAIDEN NAME <u>MAUDE CHALLENGE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>N/A</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	17. INFORMANT <u>COY A STOKES</u> Address* <u>740 CROWDER</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>Coronary Thrombosis</u> <u>Pulmonary Embolism</u> <u>Essential Hypertension</u> DUE TO (b) <u>Rheumatic Heart Disease</u> DUE TO (c) <u>Myocardial Infarction</u> 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 <u>Found</u> <u>May 24</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>416x</u>	
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 <u>June 6 - 1957</u> and last saw her <u>July 15 - 57</u> Death occurred <u>July 15 - 57</u> at the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Earl Hilleman</u>		22b. ADDRESS <u>634 W. 1st St</u>	
22c. DATE SIGNED <u>7/17/57</u>		22d. SIGNATURE <u>Earl Hilleman</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>7/17/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WICHITA CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>WICHITA KANSAS</u>
24. FUNERAL DIRECTOR <u>EARL HILLEMAN 9709 LACKLAND RD</u>		25. DATE RECD. BY LOCAL REG. <u>JUL 17 '57</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith</u>

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.....
Emb. W. H. Williams

Licensed Embalmer No. *358*

P. O. Address *Overland*

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.