

Health Welfare Public Service
 300
 1-56
 All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. 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.

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

26842

FILED JUL 17 1957

STATE FILE NUMBER 1520

Registration District No. 317 Primary Registration District No. 542 Registrar's No. 1520

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before institution) a. STATE Mo. b. COUNTY St. Louis			
b. CITY (If outside corporate limits, give TOWNSHIP only) Ferguson		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Bellefontaine 4079		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Halls Ferry			Length of stay in lb 1 mo.	d. STREET ADDRESS 10157 Cabot Dr.			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Anna				Middle L.	Last Kinker	4. DATE OF DEATH Month 6 Day 12 Year 57	
5. SEX Female	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 Apr. 26, 1885		9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Keigher				14. MOTHER'S MAIDEN NAME Bridgett Owen			
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 George F. Kinker, 10157 Cabot Dr.			
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						INTERVAL BETWEEN ONSET AND DEATH 1 week	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Atherosclerotic Cardiovascular Disease				DUE TO (c) unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Parkinson's Syndrome						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 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 May 17, 1957 to June 12, 1957 and last saw her alive on 6/10/57 Death occurred at 3:10 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Lewis Littenman M.D.				22b. ADDRESS 8231 Clayton Rd (17)		22c. DATE SIGNED 6/11/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 6/15/57	23c. NAME OF CEMETERY OR CREMATORY Fee Fee Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County Mo.			
24. FUNERAL DIRECTOR Drehmann-Harrel			ADDRESS 1905 Union	25. DATE RECD. BY LOCAL REG. 6-15-57		26. REGISTRAR'S SIGNATURE Herkert B. Dambina	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. Lewis E. Littmann
8231 Clayton Rd.
Pa. 7-0202

Hrs. 3 - 5 PM Fri.

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 *Warren A. Carver* _____

Licensed Embalmer No. 35

P. O. Address _____

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.