FILED SEP 4 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

29335

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7857

1. PLACE OF DEATH
a. COUNTY Saint Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 39 Cardinal Glennon Memorial Hospital — Length of stay in 1b 3 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Illinois b. COUNTY /
c. CITY OR TOWN O'Fallon 8120 — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 32 310 S. Walnut — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Joyce Middle Elaine Last Corbier
4. DATE OF DEATH Month Aug. Day 20 Year 1957
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 5-10-49
9. AGE (In years last birthday) 8 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (City and state or country) Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Corbier, Henry
14. MOTHER'S MAIDEN NAME Moyers, Elaine
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Henry Corbier

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGENITAL HEART DISEASE (INTERVENTRICULAR SEPTAL DEFECT) — INTERVAL BETWEEN ONSET AND DEATH SINCE BIRTH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) OPERATIVE CLOSURE OF SEPTAL DEFECT
DUE TO (c) ADDITIONAL DEFECTS ATRIOVENTRICULARIS COMMUNIS VASCULAR RING
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 754.2
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

Joseph M. Greene
Joseph Greene
8/27/57

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 August 17, 1957, to August 20, 1957 and last saw her/him alive on August 20, 1957
Death occurred at 1:35 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) William J. Fitzpatrick M.D.
22b. ADDRESS 1465 S. Grand St. Louis Mo
22c. DATE SIGNED Aug 21, 1957

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE Aug. 23, 1957
23c. NAME OF CEMETERY OR CREMATORY O'Fallon City Cemetery
23d. LOCATION (City, town, or county) O'Fallon (State) Illinois

24. FUNERAL DIRECTOR P.W. Schildknecht ADDRESS O'Fallon, Illinois
25. DATE RECD. BY LOCAL REG. AUG 22 '57
26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

NOT Emb

I hereby certify that the body whose name is recorded on the reverse side of this certificate was er

by me, or by ....., Student Embalmer No.....

working under my personal supervision...

Student.....
Signature of Student Embalmer

Signed....P. H. Schildknecht.....

Licensed Embalmer No 8549.

P. O. Address O'Fallon, .

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.