THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED AUG 26 1957

29392 STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7409

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes X No ☐	c. CITY OR TOWN St. Louis — Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Deaconess Hosp. — Length of stay in lb ½ hr.	d. STREET ADDRESS (If outside, give location) 4739 Carter Ave. — Reside on Farm Yes ☐ No X

08 27

3. NAME OF DECEASED (Type or print)	First LOUISE	Middle F.	Last DUGGAN
4. DATE OF DEATH	Month Aug.	Day 6,	Year 1957
5. SEX female	6. COLOR OR RACE white	7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
8. DATE OF BIRTH May 15, 1896	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months 2 Days 21	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Fred Schmidt		14. MOTHER'S MAIDEN NAME Catherine Castlemann	
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. none	17. INFORMANT Cornelius Duggan Address 4739 Carter	

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) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH 15 mins.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis — 5 yrs +

DUE TO (c) 332 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Obesity

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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 ~~June 1, 1956~~ Aug 1, 1952, to Aug 6, 1957 and last saw her/him alive on Nov. 9, 1956. Death occurred at 6.45 a m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Birkle Ock MD

22b. ADDRESS 508 N. Grand

22c. DATE SIGNED Aug 8, 57

23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE Aug 9, 1957	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR Bromschwig and Son/W Florissant	ADDRESS 4746	25. DATE RECD. BY LOCAL REG. AUG 8 '57	26. REGISTRAR'S SIGNATURE J Carl Smith MD MJB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

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

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

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed John J. Haines

Licensed Embalmer No. 41

P. O. Address St. Louis

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.