

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29431

STATE FILE NUMBER

FILED SEP 4 1957

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7322

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Endorville</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <i>St. Louis City Hospital #1</i>		(If NOT in hospital, give location) Length of stay in lb	d. STREET ADDRESS <i>3127 Locust St</i>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Molly</i> Middle Last <i>Fish</i>			4. DATE OF DEATH Month <i>August</i> Day <i>2</i> Year <i>1957</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>UNKNOWN</i>	9. AGE (In years last birthday) <i>62</i> IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>498-26-9794</i>	11. BIRTHPLACE (City and state or country) <i>unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>UNKNOWN</i>
13. FATHER'S NAME <i>unknown</i>			14. MOTHER'S MAIDEN NAME <i>unknown</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Bessie Wilson</i> Address <i>6116a Barton</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CHRONIC BRAIN SYNDROME</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>CEREBRAL ARTERIO SCLEROSIS</i> DUE TO (c) <i>GENERALIZED ARTERIO SCLEROSIS</i>					INTERVAL BETWEEN ONSET AND DEATH <i>UNKNOWN</i> <i>UNKNOWN</i> <i>UNKNOWN</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>FEMORAL THROMBOPHLEBITIS</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>2</i>
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 <i>7-22-57</i> to <i>8-2-57</i> and last saw <i>her</i> ^{her} _{her} alive on <i>8-2-57</i> Death occurred at <i>9:45a</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Type or print) <i>Daniell Mullally, M.D.</i>			22b. ADDRESS <i>1515 Lafayette</i>		22c. DATE SIGNED <i>Aug. 2, 1957</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>Aug. 6, 1957</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Matthew</i>		23d. LOCATION (City, town, or county) (State) <i>Granville + Bates Mo.</i>	
24. FUNERAL DIRECTOR ADDRESS <i>Buell-Campbell Mortuary</i>		25. DATE RECD. BY LOCAL REG. <i>AUG 6 '57</i>		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith MD</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Public Health Service
000
-56
diseases in Part I must be causally 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 embalmed
by me, ~~or by~~....., Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Elmer R. Sadron*

Licensed Embalmer No. *4*

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.