

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29523

STATE FILE NUMBER

FILED SEP 4 1957

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7611

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 <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital		Length of stay in Ib	STREET ADDRESS 5125 Wabada Ave.		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Malinda Middle Last Hart			4. DATE OF DEATH Month August Day 13 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11, 1868	9. AGE (In years last birthday) 89	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 At Home	11. BIRTHPLACE (City and state or country) Calloway Co., Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John Kohenskey			14. MOTHER'S MAIDEN NAME Henrietta Schwalby		
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 Address Helen Setzer, 5125 Wabada Ave.		
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
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) Arteriosclerotic coronary thrombosis.					2 days.
DUE TO (c) Hypertensive arteriosclerotic cardiovascular disease.					5 years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 4201					
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 September 1955 , to August 19, 1957 and last saw her alive on Aug. 13, 1957 Death occurred at 11:45 am m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) John L. Lawton, M.D.			22b. ADDRESS 634 N. Grand Blvd		22c. DATE SIGNED Aug 14, 1957
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-14-57	23c. NAME OF CEMETERY OR CREMATORY Our Lady of the Snows		23d. LOCATION (City, town, or county) Mary's Home Mo. (State)	
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd.		25. DATE RECD. BY LOCAL REG. AUG 14 57		26. REGISTRAR'S SIGNATURE J. Carl Smith MD	

(Licensed Embalmer's Statement on Reverse Side)

Use ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Coroner cannot certify to a death due to natural causes. diseases in Part I must be causally related.

MEDICAL CERTIFICATION

Missouri

x

St. Louis

x

St. Louis

x

2122 Wabasha Ave.

DePaul Hospital

August 13, 1957

Heart

Malinda

89

April 11, 1957

x

White

Female

U.S.

CAUTIONARY CO. MO.

At Home

Home

Henrietta Schwartz

John Koenigske

STATEMENT BY LICENSED EMBALMER

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

by me, or by Student Embalmer No.

working under my personal supervision.

Student
Signature of Student Embalmer

Signed *John J. Staines*
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.

REVERS

Alb. et al. Hosp. 450, Washington Ave.