

FILED AUG 19 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

29717

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

6872

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.			c. CITY OR TOWN Moline		b. COUNTY St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hospital			Length of stay in lb 5 Hours		d. STREET ADDRESS (If outside, give location) 9809 Highway #67
3. NAME OF DECEASED (Type or print) Josephine S. McCombs			4. DATE OF DEATH July, 20, 1957.		
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 12-21-1890.	9. AGE (In years last birthday) 66
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) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.,
13. FATHER'S NAME - Schaffer			14. MOTHER'S MAIDEN NAME Margaret -		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 488-09-0667A	17. INFORMANT Address Mr Charles C. McCombs, 9809 Highway #67.		
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 Hemorrhage					INTERVAL BETWEEN ONSET AND DEATH hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertensive + Arteriosclerotic Cardiovascular Disease					6 yrs.
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) 443x					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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 12-16-54 to 7-20-57 and last saw her/him alive on 7-20-57 Death occurred at 8.30 P.M. , m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Ann Higgins, M.D.			22b. ADDRESS 634 N. Grand Ave.		22c. DATE SIGNED 7-22-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7-24-1957	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery,		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri.	
24. FUNERAL DIRECTOR ADDRESS Math. Hermann & Son Inc. 2161 E. Fair			25. DATE RECD. BY LOCAL REG. JUL 23 '57	26. REGISTRAR'S SIGNATURE 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.

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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.....
Licensed Embalmer No.
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.