

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30045

STATE FILE NUMBER

7499

FILED AUG 26 1957

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

| | | | |
|--|------------------------|--|---|
| 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 | | c. CITY OR TOWN St. Louis | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospt | | d. STREET ADDRESS (If outside, give location) 1815 Michigan Ave. | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Mary Staten | | 4. DATE OF DEATH Month Day Year 8-9-57 | |
| 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 1-30-1884 |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursing | | 9. AGE (In years last birthday) 73 | |
| 10a. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Ky. | |
| 13. FATHER'S NAME Stuart Allen | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14. MOTHER'S MAIDEN NAME Laura Unk. | | 17. INFORMANT Address Jane Schlosser 1815 Michigan Ave. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Atherosclerosis DUE TO (c) Obesity PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 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 a. m. p. m. | | 20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from 2-28-55 to 8-9-57 and last saw her alive on 8-9-57 Death occurred at 10:12 p. on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) D. Sommer | | 22b. ADDRESS 2504 th Delmar | |
| 22c. DATE SIGNED 8/12/57 | | | |
| 26. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 8-13-57 | 23c. NAME OF CEMETERY OR CREMATORY Bethany Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo. |
| 24. FUNERAL DIRECTOR J.W. Clark F.H 1125 Hodiament | | 25. DATE RECD. BY LOCAL REG. AUG 12 1957 | |
| | | 26. REGISTRAR'S SIGNATURE [Signature] | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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

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 *Alfred J. Bradeke*.....
Licensed Embalmer No. 2.....

P. O. Address 112 5th.....

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.