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Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. ATT
diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED OCT 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 33667

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9014

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) St.Anthony Hospital — Length of stay in 1b 22	d. STREET ADDRESS (If outside, give location) 3185 Nebraska Ave. 24 — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print): First Erle; Middle M.; Last Hutchinson

4. DATE OF DEATH: Month Sept. Day 26 Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 14, 1904

9. AGE (In years last birthday): 53 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeping

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (City and state or country): St.Louis, Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Preston

14. MOTHER'S MAIDEN NAME: Bertha Warriner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown — (If yes, give war or dates of service): -------

16. SOCIAL SECURITY NO. 497-18-6706

17. INFORMANT: Charles M. Hutchinson — Address: 3185 Nebraska

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) Coronary Occlusion
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) A.S C V D Disease
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4201

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑ 2

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 9-10-57 to 9-26-57 and last saw her/him alive on 9-25-57
Death occurred at 12:15 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Charles A Hester MD (Degree or title)

22b. ADDRESS 5600 S Compton

22c. DATE SIGNED 9-26-57

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: Sept.30,1957

23c. NAME OF CEMETERY OR CREMATORY: Park Lawn Cemetery

23d. LOCATION (City, town, or county) (State): St.Louis County, Missouri

24. FUNERAL DIRECTOR: WACKER-HELDERLE — ADDRESS: 3634 Gravois Ave.

25. DATE RECD. BY LOCAL REG. SEP 27 57

26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

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

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

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Robert C Wheeler

Licensed Embalmer No. 2

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.