Health, Welfare Public Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All 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

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 33972

FILED OCT 4 1957

Registration District No. 318 Primary Registration District No. 1003 Registrar's Serial No. 8968

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St Louis — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Bethesda Hosp — Length of stay in 1b: 05

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY:
c. CITY OR TOWN: St.Louis — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 3836a Minnesota — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First ALMA Middle L Last PERMENTER
4. DATE OF DEATH: Month Sep Day 23 Year 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 31 1874
9. AGE (In years last birthday): 83 — 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (City and state or country): Bells Tenn
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Wily Jones
14. MOTHER'S MAIDEN NAME: Belle Harrison
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Ruth Adams — Address: 3836a Minnesota

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): Chronic Lymphatic Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 1 year
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): —
DUE TO (c): — 204.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

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.): none
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year: no
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 10/13/56 to 9/23/57 and last saw her alive on 9/23/57
Death occurred at 7:50 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Preston C Kell (Degree or title) MD
22b. ADDRESS: 3902 Lafayette
22c. DATE SIGNED: 9/23/57

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Sep 25 57
23c. NAME OF CEMETERY OR CREMATORY: Cypress
23d. LOCATION (City, town, or county) (State): Bells Tenn.

24. FUNERAL DIRECTOR: E.J.Schnur ADDRESS: 3125 Lafayette
25. DATE RECD. BY LOCAL REG.: SEP 25 57
26. REGISTRAR'S SIGNATURE: J. Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

PRESTON HALL

STATEMENT BY LICENSED EMBALMER

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

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

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Thomas R. Fenwick

Licensed Embalmer No. 3

P. O. Address 3125 Lag

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.