

FILED SEP 17 1957

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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 type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 27 Homer Phillips		Length of stay in 1b	4. DATE OF DEATH 9-1-57 STREET ADDRESS 497 4964 Beacon (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ROY A. PETTIBONE			4. DATE OF DEATH 9-1-57
5. SEX 0 male	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 11-24-1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) self employed		10b. KIND OF BUSINESS OR INDUSTRY Brake Service	9. AGE (In years last birthday) 54 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME James Pettibone		13b. MOTHER'S MAIDEN NAME Amanda Cornwall	14. NAME OF HUSBAND OR WIFE Rose
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 Rose Pettibone, 4964 Beacon 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) <u>Coronary occlusion.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Vegetative Endocarditis</u> DUE TO (c) <u>Valvular disease Rheumatic</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
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.) 414 X	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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 <u>July 1957</u> to <u>Aug 30-57</u> and last saw her alive on <u>Aug 28-57</u> Death occurred at <u>11:52 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Joseph J. Keisler M.D.</u>		22b. ADDRESS <u>3504 71st St.</u>	22c. DATE SIGNED <u>9-4-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>9-4-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>
24. FUNERAL DIRECTOR <u>Heilitag, Imperia, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-3-1957</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Homer W. Fritz*

Licensed Embalmer No. *3882*
P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure 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.