

Health,  
Welfare  
Public  
Service

300  
1-56

This form must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED SEP 23 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34391

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2218

|   |  |  |  |   |   |
|---|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>   |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b> |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><b>Clayton</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN<br><b>Maplewood</b>  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION<br><b>St. Louis Co. Hospital</b>  |  |  | Length of stay in lb<br><b>1 day</b>   | d. STREET ADDRESS<br><b>3138 Big Bend Road</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Ada L. Skyles</b>   |  |  | 4. DATE OF DEATH<br><b>Sept. 4, 1957</b>   | 5. SEX<br><b>Female</b>   |   |
| 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED <input checked="" type="checkbox"/></b> | 8. DATE OF BIRTH<br><b>July 30, 1887</b>   | 9. AGE (In years last birthday)<br><b>70</b>   | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>                       |
| 11. BIRTHPLACE (City and state or country)<br><b>Kimmswick, Missouri</b>  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |   |
| 13. FATHER'S NAME<br><b>David J. White</b>  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Preister</b>   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  | 16. SOCIAL SECURITY NO.<br><b>none</b>   | 17. INFORMANT<br><b>James L. Skyles, 3926 Parnell Avenue</b>                         |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Recent Myocardial Infarction</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic heart disease</b><br>DUE TO (c) <b>4200</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b> |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>unknown</b>                        |
| 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<br>Hour <input type="checkbox"/> Month, Day, Year<br>a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>  |  |  |  |   |   |
| 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<br>COUNTY<br>STATE                                      |  |   |   |
| 21. I attended the deceased from <b>9-3-1957</b> to <b>9-4-1957</b> and last saw her <input checked="" type="checkbox"/> alive on <b>9-4-1957</b><br>Death occurred at <b>2:20 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.  |  |  |  |   |   |
| 22a. SIGNATURE<br><b>Robert W. Skyles</b>   |  |  | 22b. ADDRESS<br><b>601 S. Brentwood Clayton</b>  | 22c. DATE SIGNED<br><b>9-5-57</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>Sept 7, 1957</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Laurel Hill Cemetery</b>                    | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis County, Missouri.</b>  |   |   |
| 24. FUNERAL DIRECTOR<br><b>Shepard Funeral Home, 1167 Hamilton Ave</b>  |  | 25. DATE RECD. BY LOCAL REG.<br><b>9-6-57</b>  | 26. REGISTRAR'S SIGNATURE<br><b>Herbert B. Bonke MD</b>  |   |   |

(Licensed Embalmer's Statement on Reverse Side)

*aac*

**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..... *Elms R Cadwell*

Licensed Embalmer No. *40*

P. O. Address *St Louis*

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.