

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37630**

FILED OCT 29 1957

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9794**

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, write RURAL and give township) St. Louis,		c. CITY OR TOWN St. Louis,	
c. LENGTH OF STAY (in this place) 1-Mo-30-Days		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hospital.		e. STREET ADDRESS (If rural, give location) 1112 N. 8th. St. Apt. 207.	
3. NAME OF DECEASED (Type or Print) Celeste Inge.		4. DATE OF DEATH (Month) (Day) (Year) October 18, 1957	
5. SEX Female	6. COLOR OR RACE White.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Sep.	8. DATE OF BIRTH 6/12/1893
9. AGE (In years last birthday) 64		IF UNDER 1 YEAR Months	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 self	11. BIRTHPLACE (City and State or Foreign Country) Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Thomas Macklin.	
13b. MOTHER'S MAIDEN NAME Margaret Gibbons		14. NAME OF HUSBAND OR WIFE Charles	
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. —	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. H. Clower 1112 N. 8th St.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardiovascular Dis.		DUPLICATE (b) Arteriosclerotic Heart Dis.		2 mo
DUPLICATE (c) Generalized Arteriosclerosis		DUPLICATE (d) Multiple Sclerosis		2 mo
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Multiple Sclerosis				2 mo
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 420.0
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **August 19, 1957**, to **October 18, 1957**, that I last saw the deceased alive on **October 18, 1957**, and that death occurred at **5:25 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John W. Beckham, M.D.		23b. ADDRESS 5800 Arsenal St.	23c. DATE SIGNED 10/18/57
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Oct. 21 1957	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
DATE REC'D BY LOCAL REG. OCT 19 57	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	FUNERAL DIRECTOR'S SIGNATURE ADDRESS Joe A. Howard 1619 So. Grand	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Robert M. W. Lewis*

Licensed Embalmer No. *3749*

P. O. Address *St. Louis, Mo.*

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.