

Health, Welfare & Public Services

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 causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED NOV 15 1957

STANDARD CERTIFICATE OF DEATH

38652

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2621

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Berkeley City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Clayton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Penn Nursing Home</u>			Length of stay in 1b <u>6 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>7563 York Dr.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Leslie</u> Last <u>Hume</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>22</u> Year <u>1957</u>									
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 11, 1873</u>		9. AGE (In years last birthday) <u>84</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (City and state or country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Peter Brodie</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>William L. Hume, 7563 York Dr.</u>								
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>Arteriosclerotic Cardiovascular disease unknown</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>										INTERVAL BETWEEN ONSET AND DEATH <u>44 3x</u>			
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 Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____													
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		COUNTY		STATE				
21. I attended the deceased from <u>July 14, 1953</u> to <u>Oct 22, 1957</u> and last saw <u>her</u> alive on <u>10-16-57</u> Death occurred at <u>7:15</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Lewis L. Baumann MD</u> (Degree or title)				22b. ADDRESS <u>8231 Clayton Rd</u>				22c. DATE SIGNED <u>10-22-57</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>10-23-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Normandy, Missouri</u>						
24. FUNERAL DIRECTOR <u>Baumann Bros. Inc.</u> 2504 Woodson Rd. Overland 14, Mo.				25. DATE RECD. BY LOCAL REG. <u>10-22-57</u>		26. REGISTRAR'S SIGNATURE <u>Hebert R. Donke, MD</u>							

(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 embalmed by me, or by, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

David C. Gibson

Licensed Embalmer No. *34*

P. O. Address *Overland*

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.