

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.

Specific name required by F.S. 140 MARKS 1949.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED NOV 22 1957

4030  
STATE FILE NUMBER  
2820

Registration District No. 317 Primary Registration District No. 545 Registrar's No. 2820

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST. LOUIS</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MAPLEWOOD</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>MAPLEWOOD</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>7337 ELM</b>			Length of stay in lb <b>3 MONTHS</b>		d. STREET ADDRESS (If outside, give location) <b>7337 ELM</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>NINA</b> Middle <b>-</b> Last <b>KIRK</b>				4. DATE OF DEATH Month <b>11</b> Day <b>17</b> Year <b>57</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-28-1885</b>		9. AGE (In years last birthday) <b>71</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>AT-HOME</b>		11. BIRTHPLACE (City and state or country) <b>NEWTON Co MO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>
13. FATHER'S NAME <b>JOSEPH BERRY</b>				14. MOTHER'S MAIDEN NAME <b>JENNIE WYATT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>MRS HERMAN W. JAHN-7337 ELM.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>-</b>		DUE TO (c) <b>-</b>		<b>4200</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>CHRONIC Rheumatoid Arthritis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</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.) <b>-</b>				
20c. TIME OF INJURY Hour a. m. p. m. <b>-</b>			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>				
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from <b>Aug 29 1957 to Nov 17 1957</b> and last saw her <sup>live</sup> alive on <b>Nov 17, 1957</b> Death occurred at <b>1 A M</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Vincent J Gonnensend MD</b>				22b. ADDRESS <b>3101 S Sutton Ave Maplewood Mo</b>		22c. DATE SIGNED <b>11-17-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>11-17-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OZARK-MEMORIAL PARK-CEN</b>		23d. LOCATION (City, town, or county) (State) <b>Joplin Mo</b>		
24. FUNERAL DIRECTOR ADDRESS <b>JAY-B-SMITH-Maplewood 11 Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>11-17-57</b>		26. REGISTRAR'S SIGNATURE <b>Herbert A. Romke MD</b>		

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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.....  
*J. Allen Davis*

Licensed Embalmer No. 405

P. O. Address.....  
*W. L.*

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.