

pt. Health,
c. & Welfare
S. Public
lth Service

FILED DEC 10 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER
500 Registrar's No. 2979

Registration District No. 317 Primary Registration District No. 500

ES. 300
v. 1-57

400

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) Normandy		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION O'Sullivan Nursing Home-1111 Mon.		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 5416 Hodiadont Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HULDAH Middle M. Last WATERS			4. DATE OF DEATH Month Nov. Day 26 Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1868
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) St. Louis Co., Mo.
13a. FATHER'S NAME John F. Howell		13b. MOTHER'S MAIDEN NAME Unknown McCourtney	14. NAME OF HUSBAND OR WIFE Late John P. Waters
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not unknown) (If yes, give type or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Olive N. Waters 5416 Hodiadont 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) Malignant Melanoma			INTERVAL BETWEEN ONSET AND DEATH unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 190x			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (but not related to the terminal disease condition given in PART I (a)) Atherosclerotic Heart Disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 Dec 18, 1956 to Nov 26, 1957 and last saw her ^{him} alive on 11/25/57 Death occurred at 2:00 A. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Lewis Kitzmann MD (Degree or title)		22b. ADDRESS 8731 Clayton RA	22c. DATE SIGNED 11/26/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov. 29, 1957	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway		25. DATE RECD. BY LOCAL REG. 11-26-57	26. REGISTRAR'S SIGNATURE Herbert R. Doncke MD

ccc

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 *William B. White*

Licensed Embalmer No. *4281*

P. O. Address *4228 Holmgren*

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.