

Health & Welfare Public Service

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 DEC 20 1957

STANDARD CERTIFICATE OF DEATH

468599
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3032

1. PLACE OF DEATH a. COUNTY <u>St Louis COUNTY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis Clayton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Unincorporated Area</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If not in hospital, give location) Length of stay in 1b <u>St Louis CO Hosp 5 1/2 hrs</u>				d. STREET ADDRESS (If outside, give location) <u>9841 Meebs</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ollie</u> Middle <u>Mc</u> Last <u>Donald</u>			4. DATE OF DEATH Month <u>11</u> Day <u>27</u> Year <u>57</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</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>4-14-1870</u>	
9. AGE (In years last birthday) <u>87</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		100. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Memphis Tenn, U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MARDEN 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>Unknown</u>		17. INFORMANT Name <u>D Lucella Brownlee</u> Address <u>9841 Meebs</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>myocardial infarction</u>						INTERVAL BETWEEN ONSET AND DEATH	
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>generalized arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u>4:20</u> Month, Day, Year							
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>11-27-57</u> to <u>11-27-57</u> and last saw ^{her} _{him} alive on <u>11-27-57</u> Death occurred at <u>1:19 p. m</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Robert J. Saar MD</u>				22b. ADDRESS <u>601 S. Brentwood, Clayton, Mo.</u>		22c. DATE SIGNED <u>11-29-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-3-57</u>		<u>Washington Park</u>		<u>Berkeley Missouri</u>	
24. FUNERAL DIRECTOR <u>E. B. Koonce</u>		ADDRESS <u>1221 N. Grand</u>		25. DATE RECD. BY LOCAL REG. <u>12-3-57</u>		26. REGISTRAR'S SIGNATURE <u>Herbert R. Donker MD</u>	

(Licensed Embalmer's Statement on Reverse Side)

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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 *Clarence Crooms*

Licensed Embalmer No. *475*

P. O. Address *1221 N. J.*

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.