

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

87522

STATE FILE NUMBER

FILED JAN 17 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

12216

V. S. 300
 Rev. 1-57

securing the medical certification in the specific manner required by 193.140 MoRS 1949.
 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
 MEDICAL CERTIFICATION

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, give TOWNSHIP only) OR TOWN St. Louis		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 Enroute City Hospital			Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 2670 2808 N. 9th St.			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Albert Middle Walter Last Decker				4. DATE OF DEATH December 18, 1957 Month Day Year			
5. SEX Male	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 April 8, 1885		9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner			10b. KIND OF BUSINESS OR INDUSTRY Lead Mine	11. BIRTHPLACE (City and state or country) Iron Co., Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Unknown			13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Stella Decker		
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. 191-18-5907		17. INFORMANT Address Opal Farrell, Desloge, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arterio Sclerosis							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						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 Month, Day, Year a.m. p.m.							
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 _____ to _____ and last saw her alive on _____ Death occurred at 219 A m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Deceased or title) James M Kelly Coroner				22b. ADDRESS 1300 Clark		22c. DATE SIGNED 12-19-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-18-57	23c. NAME OF CEMETERY OR CREMATORY Local		23d. LOCATION (City, town, or county) (State) Desloge, Mo.		
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd.				25. DATE RECD. BY LOCAL REG. DEC 19 57		26. REGISTRAR'S SIGNATURE Paul Smith MD m 8 B	

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 *John D. Ambler*

Licensed Embalmer No. *3053*

P. O. Address *St Louis 8, 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. -II-
If this body is not embalmed, fact should be so stated above.