

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3235

STATE FILE NUMBER
1183

FILED FEB 14 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

UNDER TAKER TO BRING CERTIFICATE TO CORNER FOR APPROVAL
All diseases in Part I must be causally related
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms which are related
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | | | |
|--|----------------------------------|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>City of St. Louis</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis Mo</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>St. Louis. Mo</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>Missouri Pacific</u> | | Length of stay in lb <u>2</u> | d. STREET (If outside, give location) <u>6058 A. Carlsbad</u> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MRS. ANNIE - LOWER</u> | | | 4. DATE OF DEATH Month Day Year <u>Jan-30-1958</u> | | |
| 5. SEX <u>F</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>Sept. 19. 1859</u> | | 9. AGE (In years last birthday) <u>98</u> |
| 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>none</u> | | 11. BIRTHPLACE (City and state or country) <u>Wisconsin</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13a. FATHER'S NAME <u>John Kocian</u> | | 13b. MOTHER'S MAIDEN NAME <u>Unk.</u> | |
| 14. NAME OF HUSBAND OR WIFE | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, year or unknown) (If yes, give year or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>unk</u> | |
| 17. INFORMANT <u>Hazel McFadon</u> | | Address <u>6058a Carlsbad</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>Fracture Right Femur at Hip</u> DUE TO (b) <u>BRONCHO-PNEUMONIA</u> 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>44</u> | |
| INTERVAL BETWEEN ONSET AND DEATH <u>1-9-58</u> <u>1-17-58</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT <input checked="" 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.) <u>Fall on floor - MILLER NURSING HOME</u> | | 20c. TIME OF INJURY Hour Month, Day, Year <u>2 PM JAN-9-58</u> | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg., etc.) <u>NURSING HOME</u> | | 20f. CITY, TOWN, OR LOCATION <u>St. Louis County - Mo</u> | | 21. I attended the deceased from <u>JAN-9-1958</u> to <u>JAN-30-58</u> and last saw her/him alive on <u>JAN-30-1958</u> Death occurred at <u>7:20 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>Joseph A. Lembar, M.D.</u> | | 22b. ADDRESS <u>607 N. GRAND BLVD</u> | | 22c. DATE SIGNED <u>1-31-58</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 23b. DATE <u>2-1-58</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Missouri Crematory</u> | |
| 23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u> | | 24. FUNERAL DIRECTOR ADDRESS <u>Southern Funeral Home 6322 S Grand Blvd., S. Louis, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>Jan. 58</u> | |
| 26. REGISTRAR'S SIGNATURE <u>J. Earl Smith III</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 Van Fossen*

Licensed Embalmer No. *4242*
P. O. Address *St. Louis, 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. -- --
If this body is not embalmed, fact should be so stated above.