

FILED JAN 30 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3718  
STATE FILE NUMBER  
641  
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

100  
-57

1. PLACE OF DEATH a. COUNTY			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>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</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>St. Lukes Hospital</b>		Length of stay in lb <b>2 hours</b>	d. STREET ADDRESS (If outside, give location) <b>650 6053 Waterman</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>Agnes</b> Last <b>Vance</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>17th.</b> Year <b>1958</b>		
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 18th, 1902</b>		9. AGE (In years last birthday) <b>55</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Advertising</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Advance Time Service</b>	11. BIRTHPLACE (City and state or country) <b>Rochester New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Harvey George Vance</b>		13b. MOTHER'S MAIDEN NAME <b>Mamie T. Downey</b>		14. NAME OF HUSBAND OR WIFE <b>Never Married</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no no</b>		16. SOCIAL SECURITY NO. <b>113-03-0846</b>		17. INFORMANT <b>Russell W. Vance</b> Address <b>5941 Julian</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>Coronary thrombosis - left anterior &amp; posterior</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 days 3 hours</b>
DUE TO (b) <b>Coronary atherosclerosis</b>					?
DUE TO (c) <b>Hypertensive cardiovascular disease - arteriosclerotic</b>					<b>5 years plus</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Healed tuberculosis spleen. Cholelithiasis</b>					19. WAS AUTOPSY PERFORMED? <b>YES</b> <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.) <b>420.1A</b>		
20c. TIME OF INJURY Hour a.m. p.m.					
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 <b>1955</b> to <b>1-17-58</b> and last saw her <sup>him</sup> alive on <b>1-17-58</b> Death occurred at <b>1-17-58</b> <b>4:45 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>J. F. Deane, M.D.</b>			22b. ADDRESS <b>864 Hamilton Blvd St. Louis 12 Mo.</b>		22c. DATE SIGNED <b>1-18-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>1-20-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri</b>
24. FUNERAL DIRECTOR <b>Arthur J. Donnelly</b> ADDRESS <b>3840 Lindell Blvd.</b>			25. DATE RECD. BY LOCAL REG. <b>JAN 20 '58</b>		26. REGISTRAR'S SIGNATURE <b>J. Carl Smith Mo</b> <b>m86</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

864 Hamlet Form  
1:30 P.M.

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, *Wm S. Sagen* .....

Licensed Embalmer No. *4699* .....  
P. O. Address *384 Dundell* .....

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.