

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-007158
STATE FILE NUMBER
1796

FILED FEB 28 1958

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. _____

300
1-57

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>25 ST. LOUIS CITY HOSP.</u>			Length of stay in lb	d. STREET ADDRESS <u>2590 4424 ITASKA</u>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle Last <u>DUCHON</u>				4. DATE OF DEATH Month <u>FEB.</u> Day <u>13</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 14 1871</u>		9. AGE (In years last birthday) <u>86</u>	10. F UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FACTORY WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LIGGETT</u>		11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>JOSEPH DUCHON</u>			13b. MOTHER'S MAIDEN NAME <u>JOSEPHINE NOYAK</u>			14. NAME OF HUSBAND OR WIFE <u>-</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, if unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>HARRY KRIEG 4424 ITASKA</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 of Left Hip</u> DUE TO (b) <u>Generalized Arterio Sclerosis</u> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Do not duplicate information in PART I or PART II of item 18.) <u>Supporter in fall and injury</u> <u>2 1/2 of hand on or about</u>				
20c. TIME OF INJURY Hour <u>3</u> a.m. Month, Day, Year <u>1 28 58</u> p.m. <u>February 28 1958</u>			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, factory, street, office bldg., etc.) <u>15 Trade</u>			20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>St Louis Mo</u>				
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>9:30</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Patrick J. Taylor Carauer</u> (Degree or title)				22b. ADDRESS <u>1300 Clark</u>			22c. DATE SIGNED <u>2-14-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>FEB 17 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>S-S. PETER & PAUL</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>		
24. FUNERAL DIRECTOR <u>Thomas Kute 2906 Gravois</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>FEB 14 '58</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

Carl Smith
mgs

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 *James C Hill*

Licensed Embalmer No. *4347*
P. O. Address *2906 Swan*

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.