Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED FEB 28 1958

58-007833

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1792

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN St. Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 09 DePaul Hospital — Length of stay in 1b 49 Yrs.	d. STREET ADDRESS (If outside, give location) 2710 3235 Geyer Ave. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print)	First MARY	Middle JANE	Last SMITH
4. DATE OF DEATH	Month February	Day 12	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	8. DATE OF BIRTH 9-23-1878
9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Rockingham, N. C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME William Newnam	13b. MOTHER'S MAIDEN NAME Mary Jane Williams	14. NAME OF HUSBAND OR WIFE Walter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. ?	17. INFORMANT Jane Bodle, 3235 Geyer Ave.	Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 8 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Hypertension — 30 years

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331 X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 2-4-58

20f. CITY, TOWN, OR LOCATION COUNTY STATE 2-12-58

21. I attended the deceased from 2-4-58, to 2-12-58 and last saw her/him alive on 2-12-58

Death occurred at 7P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) H.H.Feller H H Feller MD M.D.	22b. ADDRESS 2739 No. Grand 2739 N. Grand	22c. DATE SIGNED 2-14-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2-15-1958	23c. NAME OF CEMETERY OR CREMATORY Madison, North Carolina	23d. LOCATION (City, town, or county) (State) Madison N.C.
24. FUNERAL DIRECTOR ADDRESS McLAUGHLIN'S, 2301 Lafayette Ave.	25. DATE RECD. BY LOCAL REG. FEB 14 '58	26. REGISTRAR'S SIGNATURE J Carl Smith MD MDO	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

11-1
H H Felton
2739 [illegible]

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 R. Chapman

Licensed Embalmer No. 4550

P. O. Address [illegible]

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.