

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-011899  
STATE FILE NUMBER  
2473

FILED MAR 19 1958

Registration District No. **318** Primary Registration District No. **1073** Registrar's No. \_\_\_\_\_

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. 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>37 Frazier Nursing Home</b>				Length of stay in 1b		4. STREET ADDRESS (If outside, give location) <b>2342 Whittemore Pl</b>	
3. NAME OF DECEASED (Type or print) First <b>Mamie</b> Middle <b>Kuyath</b> Last <b>Kuyath</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>27</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar 15 1880</b>	9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Mins. _____		IF UNDER 24 HRS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>J Dougherty</b>				14. MOTHER'S MAIDEN NAME <b>Ella Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Joseph Dempsey 4700 Primm</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>Mitral Insufficiency</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Cerebral Hemorrhage Dec 1, 57</b>					
		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.) <b>410X</b>				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____							
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>Dec 2nd 1954 to Feb 27, 58</b> and last saw her alive on <b>Feb 20, 58</b> Death occurred at <b>Feb 27, 58, 5 p m</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>O. D. Meyer, M.D. O. D. Meyer, M.D.</b>				22b. ADDRESS <b>6029 S. Kingshighway Bl</b>		22c. DATE SIGNED <b>Feb 28, 57</b>	
23a. BURIAL, CREATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Mar 3 58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Picker</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Mo</b>		
24. FUNERAL DIRECTOR ADDRESS <b>E. J. SCHNUR - 3125 LAFAYETTE</b>				25. DATE RECD. BY LOCAL REG. <b>FEB 28 '58</b>		26. REGISTRAR'S SIGNATURE <i>Carol Smith</i> <b>mfb</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 *Thomas R. Fenwick*.....

Licensed Embalmer No. *37*

P. O. Address *3125 Lofgren*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.

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