Health, Welfare Public Service

300
1-57

FILED MAR 19 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-011969
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2692

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS MO — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 01 1016 N. 14th St — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY
c. CITY OR TOWN 25 ST LOUIS MO — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 1016 N 14 ST — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First CALLIE Middle Last McDAMON

4. DATE OF DEATH Month 3 Day 3 Year 58

5. SEX 3 FEMALE
6. COLOR OR RACE NEGRO
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 8-21 93
9. AGE (In years last birthday) 64 — 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) AT HOME
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) MISS.
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME UNKNOWN
13b. MOTHER'S MAIDEN NAME UNKNOWN
14. NAME OF HUSBAND OR WIFE —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT MARY ROBINS Address 1016 N 14 ST.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Labor Pneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 490 x
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

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 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.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at 737 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) James M Kelly Deputy Coroner 3
22b. ADDRESS 1300 Clark
22c. DATE SIGNED 3-6-58

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAS
23b. DATE 3-7-58
23c. NAME OF CEMETERY OR CREMATORY ODD FELLOWS
23d. LOCATION (City, town, or county) (State) JLL Centerville Township

24. FUNERAL DIRECTOR ADDRESS DRESSEL + DENT 3404 DELMAR
25. DATE RECD. BY LOCAL REG. MAR 6 '58
26. REGISTRAR'S SIGNATURE J Carl Smith MD MJB

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 Leroy A. Bannister

Licensed Embalmer No. 4523

P. O. Address 4251 Washington

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.