

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-014900

STATE FILE NUMBER

FILED APR 18 1958

Registration District No. 179 Primary Registration District No. 5667 Registrar's No. 104

0570

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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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Lincoln</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>Troy, Missouri</u> TOWN		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR <u>Maryland Heights</u> TOWN
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lincoln Co. Mem. Hospital</u>		Length of stay in lb <u>17 days</u>	d. STREET ADDRESS (If outside, give location) <u>Rt. # 1 Box # 827</u>
3. NAME OF DECEASED (Type or print) <u>BELLE</u>		4. DATE OF DEATH Month <u>April</u> Day <u>14</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 type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-18-1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Elvins, Missouri, 0</u>
13. FATHER'S NAME <u>Charles Crane</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Nellie Edwards, Moscow Mills, Mo.</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>HYPOSTATIC PNEUMONIA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>72 HRS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CONGESTIVE FAILURE, CHRONIC</u>			<u>6 mos</u>
DUE TO (c) <u>ARTERIOSCLEROTIC HT. DIS. 4200F</u>			<u>UNK.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SUBTROCHANTERIC FRACTURE RT HIP - POST OP.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <u>FELL AT HOME</u>		
20c. TIME OF INJURY Hour <u>6⁰⁰</u> Month, Day, Year <u>3 29 58</u> g.m. <u>0</u> p.m. <u>0</u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>HOME</u>	20f. CITY, TOWN, OR LOCATION <u>TROY</u>	COUNTY <u>LINCOLN</u>
21. I attended the deceased from <u>3-29-58</u> to <u>4-14-58</u> and last saw ^(her) alive on <u>4-14-58</u> Death occurred at <u>4⁰⁰ AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Louis P. Hettler MO</u>		22b. ADDRESS <u>370 E. Wood, Troy MO</u>	22c. DATE SIGNED <u>4-14-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4-16-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
24. FUNERAL DIRECTOR <u>McLAUGHLIN'S, 2301 Lafayette Ave</u>		25. DATE RECD. BY LOCAL REG <u>4-18-58</u>	26. REGISTRAR'S SIGNATURE <u>Nellie G. Schenker</u>

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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. *45*

P. O. Address *St. Louis, Mo.*

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