

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-016359
STATE FILE NUMBER

MAY 12 1958

318

1003

Registrar's No. 4458

Registration District No. _____ Primary Registration District No. _____

300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Wellston	
FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Park Lane Hospital		Length of stay in lb 2 weeks	
3. NAME OF DECEASED (Type or print) IMOGENE ELIZABETH RICE		4. DATE OF DEATH April 24, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 7, 1927
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (City and state or country) Goiconda Illinois	
13a. FATHER'S NAME Robert Sullinger		14. NAME OF HUSBAND OR WIFE Vester R. Rice.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 400-30-0926	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Toxic Adenoma (Thyroid) DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). _____		17. INFORMANT Address Vester R. Rice, 6348 Suburban Avenue	
19. WAS AUTOPSY PERFORMED? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
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.)	
20c. TIME OF INJURY _____		20d. INJURY OCCURRED WHILE AT <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 4-9-58 to 4-24-58 and last saw her alive on 4-24-58 Death occurred at 5:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Name or title) _____	
22b. ADDRESS 4930 Lindell Blvd.		22c. DATE SIGNED 4-24-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE April 26, 1958	
23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri	
24. FUNERAL DIRECTOR ADDRESS Shepard Funeral Home, 1167 Hamilton Ave		25. DATE RECD. BY LOCAL REG. APR 24 '58	
26. REGISTRAR'S SIGNATURE Carl Smith		27. _____	

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 stated. 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 *John Sherrin*
Licensed Embalmer No. *9199*
P. O. Address *St. Louis*

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.