

Health, Welfare, Public Service, 4000, 300, 1-56, All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-016872
STATE FILE NUMBER

FILED MAY 14 1958

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1130

1. PLACE OF DEATH a. COUNTY St. Louis County				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY 1			
b. CITY (If outside corporate limits, give TOWNSHIP only) Koch, Missouri			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Robt. Koch Hospital			Length of stay in 1b 60 days		d. STREET ADDRESS (If outside, give location) 1822 1/2 S. 7th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Shirley Fay Huson				Last Armstrong		4. DATE OF DEATH Month 5- Day 2- Year 58	
5. SEX Fem	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 11-1-37		9. AGE (In years last birthday) 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker		10b. KIND OF BUSINESS OR INDUSTRY Various		11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Udie Huson				14. MOTHER'S MAIDEN NAME Fern Turner			
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. 490-40-2131		17. INFORMANT Records at Robert Koch Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Glomerular Nephritis with Uremia							INTERVAL BETWEEN ONSET AND DEATH 12 years?
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) Secondary Hypertension to Nephritis							??
DUE TO (c) Chronic Anemia secondary to Nephritis							
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 checked="" type="checkbox"/> NO <input 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.) 592X				
20c. TIME OF INJURY Hour 7:30 P.M. Month, Day, Year a. m. p. m.							
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 3-3-58 to 5-2-58 and last saw her alive on 5-2-58 Death occurred at 7:30 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Harold G. Russell M.D.				22b. ADDRESS Robert Koch Hospital		22c. DATE SIGNED 5-2-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5-3-58	23c. NAME OF CEMETERY OR CREMATORY Local		23d. LOCATION (City, town, or county) (State) Naylor, Mo.		
24. FUNERAL DIRECTOR Albert H. Hoppe				ADDRESS 4700 Washington, Blvd.		25. DATE RECD. BY LOCAL REG. 5-5-58	26. REGISTRAR'S SIGNATURE Herbert R. Donham

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Stanley H. Arizon*
Licensed Embalmer No. *41*

P. O. Address *St. L.*

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.