

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-019670  
STATE FILE NUMBER

FILED JUN 5 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3461

300  
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <i>ST LOUIS</i> TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St Louis Mo.</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL INSTITUTION <i>25 ST LOUIS CITY HOSP. #1</i>		Length of stay in lb <i>0</i>	d. STREET ADDRESS (If outside, give location) <i>2170 1615 S. Grand</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <i>SAMUEL FARMER</i>			4. DATE OF DEATH Month Day Year <i>3/4/58</i>			
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5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar 30, 1884</i>	9. AGE (In years last birthday) <i>73</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>no</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	11. BIRTHPLACE (City and state or country) <i>unknown</i>	9	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13a. FATHER'S NAME <i>Samuel</i>	13b. MOTHER'S MAIDEN NAME <i>Catherine ?</i>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)	16. SOCIAL SECURITY NO. <i>?</i>	17. INFORMANT Address <i>St Louis City Hospital #1.</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>C.V.A + pulmonary edema</i>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (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"/> <i>2</i>

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.)
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20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.	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
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21. I attended the deceased from <i>2/2/58</i> to <i>3/4/58</i> and last saw her alive on <i>3/4/58</i> Death occurred at <i>10:05 P</i> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <i>C. Scholmer M.D.</i>	22b. ADDRESS <i>1515 LAFAYETTE</i>	22c. DATE SIGNED <i>3/6/58</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>	23b. DATE <i>4-18-58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St Louis Co., Mo.</i>
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24. FUNERAL DIRECTOR <i>Morrell Mortuary</i>	ADDRESS <i>3710 N. Grand</i>	25. DATE RECD. BY LOCAL REG. <i>3-26-58</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith Mo</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms w/h. be listed. 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 *Leon E. Perry* .....

Licensed Embalmer No. *4094*

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

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.