

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-023912

STATE FILE NUMBER

FILED JUN 16 1958

Registration District No. 317 Primary Registration District No. 531 Registrar's No. 1527

health, Welfare, Public Service, 300, 1-564006, Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually 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 <b>ST. LOUIS</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST. LOUIS</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>UNIVERSITY CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>UNIVERSITY CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>7804 BALSON AV.</b>		Length of stay in lb <b>YES.</b>	d. STREET ADDRESS (If outside, give location) <b>7804 BALSON AV.</b>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>FLORENCE</b> Middle <b>BERTHA</b> Last <b>CARMICHAEL</b>			4. DATE OF DEATH Month <b>JUNE</b> Day <b>6</b> Year <b>1958</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 15 1878</b>	9. AGE (In years last birthday) <b>79</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	11. BIRTHPLACE (City and state or country) <b>NEWARK, INDIANA!</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>DANIEL LYONS</b>			14. MOTHER'S MAIDEN NAME <b>EMMA DRAKE</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT Address <b>DR. D. V. CARMICHAEL 7804 BALSON AV.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) <b>Arteriosclerotic Heart Disease</b> <b>15 years</b>
DUE TO (c) <b>Generalized Arteriosclerosis</b> <b>20 years</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic cholecystitis</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <b>4200</b>			
20c. TIME OF INJURY Hour _____ Month _____ Day _____ a. m. _____ 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	
21. I attended the deceased from <b>May 29, 1958</b> and last saw her <b>June 6, 1958</b> and last saw him <b>May 29, 1958</b> Death occurred at <b>one ten p m</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Rudolph P. Catanzaro, M.D.</b>		22b. ADDRESS <b>1194 Hodiarnont, City</b>		22c. DATE SIGNED <b>6/7/58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>JUNE 8, 1958</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FAIRVIEW CEM.</b>	
23d. LOCATION (City, town, or county) <b>VINCENNES, INDIANA.</b>		24. FUNERAL DIRECTOR ADDRESS <b>M. J. CROGHAN 7146 MANCHESTER ST. LOUIS 17 MO</b>		25. DATE RECD. BY LOCAL REG. <b>6-7-58</b>	
26. REGISTRAR'S SIGNATURE <b>Herbert R. Donke M.D.</b>					

(Licensed Embalmer's Statement on Reverse Side)

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.....  
*Clarence M. Bell*

Licensed Embalmer No. *437*

P. O. Address *St. Louis*

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.