

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-030314

STATE FILE NUMBER

FILED AUG 28 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

7344

S. 300
7-157

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
27 FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Homer Phillips</u>		Length of stay in lb <u>24 days</u>	d. STREET ADDRESS <u>5923 Floy Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle East <u>SADIE D. DEVANEY</u>			4. DATE OF DEATH Month Day Year <u>July 25 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>Oct. 30, 1873</u>		9. AGE (In years at birthday) <u>84</u> IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Not Known</u>		13b. MOTHER'S MAIDEN NAME <u>Not Known</u>		14. NAME OF HUSBAND OR WIFE	
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>Mrs. Lawrence Nibberich 5923 Floy Ave.</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>Fracture of left femur, arterio sclerotic heart</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) <u>disease suffered when deceased fell from bed at the Shamrock Rest Home, 3709 Maryland, Pine Lawn, Mo. on July 3, 1958 at 12:30 a.m.</u> DUE TO (c) <u>Accident</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a) <u>Accident</u>					INTERVAL BETWEEN ONSET AND DEATH
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>See above E 9027</u>			
20c. TIME OF INJURY Hour Month, Day, Year <u>12:30 p.m. 7-3-58</u>		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <u>27 Rest Home</u>			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>27 Rest Home</u>		20f. CITY, TOWN, OR LOCATION <u>Pine Lawn Mo.</u>		COUNTY STATE <u>Mo.</u>	
21. I attended the deceased from _____ to _____ and last saw ^{her} _{him} alive on _____ Death occurred at <u>7:58 a.m.</u> _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>James M Kelly Colonel</u>			22b. ADDRESS <u>1300 Clark</u>		22c. DATE SIGNED <u>7-28-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>7/28/58</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>Buchholz Mortuary 5967 W. Florissant</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>JUL 28 58</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> <u>mcb.</u>

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 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 *W. E. Buchholz*
Not Embalmed

Licensed Embalmer No. *4557*
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.