t. Health,
, & Welfare
. Public
th Service

S. 300
v. 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-030470
STATE FILE NUMBER

FILED AUG 28 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7638

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis 0 — Inside Limits Yes ☐ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Louis City Hosp. #1 — Length of stay in 1b 25

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY

c. CITY OR TOWN St. Louis — Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 2246a Missouri — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Lula Middle B. Last Hall

4. DATE OF DEATH Month 8 Day 3 Year 58

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ 3

8. DATE OF BIRTH 5/18/1893

9. AGE (In years last birthday) 65 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (City and state or country) Indiana

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John Mather

13b. MOTHER'S MAIDEN NAME Unknown

14. NAME OF HUSBAND OR WIFE Roy

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. —

17. INFORMANT Ruby Schowengerdt, Address 1513 Valle

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 11 hours

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) 493X H
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) chronic lymphocytic leukemia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 7-31-58, to 8-3-58 and last saw her/him alive on 8-3-58
Death occurred at 3:10 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Paul A. Hein Jr. M.D. 0

22b. ADDRESS 1515 Lafayette Ave.

22c. DATE SIGNED 8-3-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 8-5-1958

23c. NAME OF CEMETERY OR CREMATORY Memorial Park

23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.

24. FUNERAL DIRECTOR McLaughlin's, ADDRESS 2301 Lafayette Ave.

25. DATE RECD. BY LOCAL REG. AUG 6 '58

26. REGISTRAR'S SIGNATURE Earl Smith MD MJB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 F. G. Farris

Licensed Embalmer No. 3384

P. O. Address F. Farris

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.