

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-030892  
STATE FILE NUMBER

FILED AUG 28 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

7621

300  
1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Phelps</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b> 0		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. James</b> 0810		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>BARNES HOSPITAL</b>		Length of stay in lb <b>3 days</b>	d. STREET ADDRESS (If outside, give location) <b>31</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>OLA</b> Middle <b>EDNA</b> Last <b>RENNER</b>			4. DATE OF DEATH Month <b>AUGUST</b> Day <b>5</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"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 20, 1884</b>		9. AGE (In years birthday) <b>73</b> FUNDER 1 YEAR Months Days Hours Min.
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>Ohio /</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>Athan A. Smith</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Norman S. Renner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Norman A. Renner, 9428 Kathlyn Dr.</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>CARDIAC FAILURE</b>					INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</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>UNKNOWN</b>
DUE TO (c) <b>GANGRENOUS GALLBLADDER 7-8 DAYS</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>420.0</b>					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.)		
20c. TIME OF INJURY Hour Month, Day, Year 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>AUG. 2, 1958</b> to <b>AUG 5, 1958</b> and last saw <sup>her</sup> / <sub>him</sub> alive on <b>AUG. 5, 1958</b> Death occurred at <b>6:35 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Doctor, or title) <i>C. C. Venillion, M.D.</i>			22b. ADDRESS <b>BARNES HOSPITAL</b>		22c. DATE SIGNED <b>8/6/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
<b>Removal</b>		<b>8-7-58</b>	<b>Memorial Park Cemetery</b>		<b>St. Louis Co., Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b>			25. DATE RECD. BY LOCAL REG. <b>AUG 6 '58</b>	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith M.D.</i>	

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *John J. Haines* .....

Licensed Embalmer No. *7108* .....

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.