Health, Welfare Public Service

300
1-56

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-031262
STATE FILE NUMBER

FILED SEP 12 1958 Registration District No. 317 Primary Registration District No. 544 Registrar's No. 2183

1. PLACE OF DEATH
a. COUNTY ST. LOUIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KIRKWOOD — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST. JOSEPH'S HOSP — Length of stay in 1b 2 WKS.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY ST. LOUIS
c. CITY OR TOWN FENTON 4000 — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) 208 WATER ST. — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First ANNA Middle M Last SMITH
4. DATE OF DEATH: Month AUG Day 18 Year 1958
5. SEX FEMALE 1
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐
8. DATE OF BIRTH APRIL 29, 1877
9. AGE (In years last birthday) 81
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) AT HOME
10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE
11. BIRTHPLACE (City and state or country) BOWLING GREEN, Mo.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHN JACKSON
14. MOTHER'S MAIDEN NAME SARAH GRIFFITH
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT MRS. J. M. SWEANEY Address FENTON, Mo.

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) Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH Immediate
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 465 X
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 ☐ NO ☐
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 8-2-58, to 8-18-58 and last saw her ~~him~~ alive on 8-18-58
Death occurred at 9:30A m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE Robert L. Preston (Degree or title) MD
22b. ADDRESS 206 N. Clay
22c. DATE SIGNED 8-19-58
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
23b. DATE 8/21/1958
23c. NAME OF CEMETERY OR CREMATORY BOWLING GREEN CEM.
23d. LOCATION (City, town, or county) (State) BOWLING GREEN, Mo.
24. FUNERAL DIRECTOR J L ZIEGENHEIN & SONS ADDRESS 7027 GRAVOIS
25. DATE RECD. BY LOCAL REG. 8-21-58
26. REGISTRAR'S SIGNATURE Herbert R. Domke M.D.

(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 em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....Donald E. Berry.....

Licensed Embalmer No. 486

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.