

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-031960

STATE FILE NUMBER

FILED SEP 30 1958

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 272

300.  
-57

1. PLACE OF DEATH a. COUNTY <b>Callaway</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Fulton</b> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> <b>2169</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>St. Hospital #1</b>		Length of stay in lb <b>1 mo. 17d</b>	d. STREET ADDRESS (If outside, give location) <b>3901 Parker</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>A.</b> Last <b>Lewis</b>			4. DATE OF DEATH Month <b>September</b> Day <b>24</b> Year <b>58</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>May 20, 1896</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>62</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>William Knollman</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Schleeter</b>	
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) <b>Unknown</b>	
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>St. Hospital #1, Fulton, Missouri</b> Address _____	
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>Carcinoma of gall bladder</b>			INTERVAL BETWEEN ONSET AND DEATH  <b>(155)</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic brain syndrome with cerebral arteriosclerosis</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 WORK <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>St. Hosp Aug. 6, 1958</b> , to <b>9/24/1958</b> and last saw him <b>XXXXXXXXXXXXXXXXXXXXXXXXXXXX</b> Death occurred at <b>12:01 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Erwin Leonhardt, M.D.</b>		22b. ADDRESS <b>St. Hospital No. 1</b>	
22c. DATE SIGNED <b>9/26/58</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	
23b. DATE <b>9/29/58</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	
23d. LOCATION (City, town, or county) <b>ST. LOUIS, MISSOURI</b>		23e. (State)	
24. FUNERAL DIRECTOR <b>MCLAUGHLIN FUNERAL HOME</b> ADDRESS <b>ST. LOUIS, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>24 September 1958</b>	
26. REGISTRAR'S SIGNATURE <b>Martha Lawrence</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

1958

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 James R. Clarke Licensed Embalmer No. 555 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.