

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-034284
STATE FILE NUMBER

FILED SEP 22 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8753

300
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital		Length of stay in lb 2-wks. 2	d. STREET ADDRESS (If outside, give location) 6439 McCune Ave.
3. NAME OF DECEASED (Type or print) First Middle Last Mary A. Halter			4. DATE OF DEATH Month Day Year Sept. 9, 1958
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1871
9. AGE (In years last birthday) Months Days Hours Min. 87	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-at home	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Sylvester Miller		13b. MOTHER'S MAIDEN NAME Margaret Geisner	
14. NAME OF HUSBAND OR WIFE Louis Halter		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. none		17. INFORMANT Address Mrs. Clara Grace, 6439 McCune Ave.	
18. CAUSE OF DEATH (Enter only one cause per factor for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Disease</u> DUE TO (b) <u>chronic nephritis</u> DUE TO (c) <u>592x</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
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 WORK <input type="checkbox"/> 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 <u>2 August</u> to <u>9 Sept 58</u> and last saw her alive on <u>9 Sept 58</u> Death occurred at <u>10 am</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>A. J. Catanzaro M.D.</u>		22b. ADDRESS <u>205 Chft.</u>	22c. DATE SIGNED <u>9 Sept 58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 12, 1958	23c. NAME OF CEMETERY OR CREMATORY Guardian Angel Cemetery	23d. LOCATION (City, town, or county) (State) Oran, Missouri
24. FUNERAL DIRECTOR <u>Arthur J. Donnelly</u>		ADDRESS 840 Lindell Blvd.	25. DATE RECD. BY LOCAL REG. SEP 10 1958
		26. REGISTRAR'S SIGNATURE <u>J. Paul Smith, M.D.</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Ms 5-117

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. S. Lagan*

Licensed Embalmer No. *4699*
P. O. Address *3840 Landall*

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.