

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-034629  
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9226  
FILED OCT 3 1958

300  
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo	
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 04 Res. 7110 Ianham		Length of stay in lb 21yrs	d. STREET ADDRESS (If outside, give location) 7110 Ianham

3. NAME OF DECEASED (Type or print) First Middle Last EVERETT YOUNGER RION			4. DATE OF DEATH Month Day Year Sept. 24, 1958		
--	--	--	--	--	--

5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1901	9. AGE (In years past birthday) 57yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
-------------	-----------------------	---	-----------------------------------	--	---	------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meter Tester	10b. KIND OF BUSINESS OR INDUSTRY Union Electric	11. BIRTHPLACE (City and state or country) Mo.	12. CITIZEN OF WHAT COUNTRY? USA
---	---	---	-------------------------------------

13a. FATHER'S NAME John Rion	13b. MOTHER'S MAIDEN NAME Maude Crawford	14. NAME OF HUSBAND OR WIFE Mrs. Ruth Crowder Rion
---------------------------------	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No	16. SOCIAL SECURITY NO. 493-05-2285	17. INFORMANT Mrs. Ruth Rion 7110 Ianham
---	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arterio sclerotic heart disease	
	DUE TO (c) 420.0	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary Emphysema.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 5-15-58 to 9-23-58 and last saw her/him alive on 9-23-58. Death occurred at 7:45 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE Robert J. Smith M.D.	(Degree or title)	22b. ADDRESS 2287 Yale Ave	22c. DATE SIGNED 9-24-58
--	-------------------	-------------------------------	-----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 26/58	23c. NAME OF CEMETERY OR CREMATORY Lakewood Park	23d. LOCATION (City, town, or county) St. Louis, Mo.
---	--------------------------	---	---

24. FUNERAL DIRECTOR Alexander & Sons 6175 Delmar	ADDRESS	25. DATE RECD. BY LOCAL REG. SEP 25 '58	26. REGISTRAR'S SIGNATURE Robert J. Smith Mo m & B
--	---------	--	--

(Licensed Embalmer's Statement on Reverse Side)

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 *Jos. E. McCulloh* .....

Licensed Embalmer No. *2760* .....

P. O. Address *4170 Illinois* .....

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.