

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-037555  
STATE FILE NUMBER

FILED OCT 17 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9722

300  
1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Saint Louis City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Saint Louis City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3504 A Vista</u>		Length of stay in lb <u>2 yrs. 8/87</u>	d. STREET ADDRESS <u>3504 A Vista</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Carolyn</u> Last <u>Alsop</u>			4. DATE OF DEATH Month <u>October</u> Day <u>8</u> Year <u>1958</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1901</u>	9. AGE (In years and birthday) <u>57</u>	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) <u>Nurses Aid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>	11. BIRTHPLACE (City and state or country) <u>Bloomfield, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>Jessie Cates</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Walker</u>		14. NAME OF HUSBAND OR WIFE <u>Chester Alsop</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>491-11-9271</u>	17. INFORMANT Address <u>Georgia Barron, 7305 Picadilly</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10/7/58</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <u>Generalized metastatic melanoma</u>					<u>9/12/58</u>
DUE TO (c) <u>Melanoma of right leg</u>					<u>2/10/58</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <u>190.7</u>					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.) <u>190.7</u>			
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 <u>April 16, 1958</u> to <u>October 8, 1958</u> and last saw <sup>her</sup> <del>him</del> alive on <u>Sept. 25, 1958</u> Death occurred <u>about 6:00 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>William H. Newman M.D.</u> (Degree or title)			22b. ADDRESS <u>1325 South Grand Blvd.</u>		22c. DATE SIGNED <u>Oct 9, 58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-9-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Local</u>		23d. LOCATION (City, town, or county) (State) <u>Bloomfield, Mo.</u>	
24. FUNERAL DIRECTOR <u>Albert H. Hoppe, 4700 Washington Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>OCT 10 58</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith M.D.</u> <u>mbs</u>	

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 Lawrence O Gerling

Licensed Embalmer No. 4979  
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.