

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-037577

STATE FILE NUMBER

NOV 10 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10215

S. 300 0  
1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Saint Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Length of stay in 1b <b>2-21-7</b>	d. STREET ADDRESS (If outside, give location) <b>3105 Thomas</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>IRENE</b> Middle <b>NMN</b> Last <b>BATLEY (BAIDY)</b>			4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>23</b> Year <b>1958</b>		
5. SEX <b>Female</b> <sup>3</sup>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <sup>2</sup> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 30, 1903</b>	9. AGE (In years last birthday) <b>55</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>23</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maid</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Barnes Hospital</b>	11. BIRTHPLACE (City and state or country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13a. FATHER'S NAME <b>Jack Henderson</b>		13b. MOTHER'S MAIDEN NAME <b>Fannie Scissem</b>		14. NAME OF HUSBAND OR WIFE <b>Deceased</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>490-36-5048</b>	17. INFORMANT Name <b>Mary Kimber</b> Address <b>3105 Thomas Street</b>		
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>CARDIAC TAMPONADE</b>					INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. } DUE TO (b) <b>DISSECTING ANEURYSM OF AORTA</b>					<b>UNKNOWN</b>
DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>					<b>UNKNOWN</b> <sup>451 X</sup>
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? 1 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 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 <b>JAN. 6, 1956</b> to <b>OCT. 23, 1958</b> and last saw her alive on <b>OCT. 23, 1958</b> Death occurred at <b>8:30 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>C. D. Hamilton, M.D.</i> M. D.				22b. ADDRESS <b>BARNES HOSPITAL</b>	
				22c. DATE SIGNED <b>10/24/58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10-27-1958</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Cemetery</b>	
				23d. LOCATION (City, town, or county) (State) <b>Berkley, Missouri</b>	
24. FUNERAL DIRECTOR <b>E. B. Koonse</b> ADDRESS <b>1221 North Grand</b>			25. DATE RECD. BY LOCAL REG. <b>OCT 25 '58</b>		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i>

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

INFORMED  
BY THE DEPARTMENT OF HEALTH  
AND HUMAN SERVICES

DATE OF DEATH (YEAR) MONTH DAY  
SEX M F AGE AT DEATH  
REGISTRATION NUMBER  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH

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 *Malvin Blouckman*

Licensed Embalmer No. *3962*  
P. O. Address: *1721 N. 1st St.*

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.