Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-041501
STATE FILE NUMBER

FILED NOV 18 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10341

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN Clayton 445 V. — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 04 BARNES HOSPITAL — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 27 619 Forest Court — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month Day Year
ANN	VODA	EASTMAN	OCTOBER 27, 1958

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
Female	White		Apr.22,1912	46		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
At home		St. Louis, Missouri	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Jacob Voda	Esther Koper	Ben Eastman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	Unk.	Ben Eastman-619 Forest Court

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) PULMONARY FIBROSIS — INTERVAL BETWEEN ONSET AND DEATH MANY YEARS

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) 525x

DUE TO (c)

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? YES ☒ NO ☐

20a. ACCIDENT ☐	SUICIDE ☐	HOMICIDE ☐	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year		
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	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 OCT. 6, 1958, to OCT. 27, 1958 and last saw her/him alive on OCT. 27, 1958

Death occurred at 6:20 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
C. Vermillion, M.D. M. D.	BARNES HOSPITAL	10/27/58

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Removal	10/29/58	Mt. Olive Cemetery	St. Louis County, Missouri

24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Herman Rindskopf, Inc. 5216 Delmar	OCT 29 58	J. Earl Smith, M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

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

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 John Kutter

Licensed Embalmer No. 3880

P. O. Address .....

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.