

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-041537
STATE FILE NUMBER
10498

FILED NOV 18 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10498

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 Saint Louis		c. CITY OR TOWN Berkeley, 21, 404/10	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital		d. STREET ADDRESS (If outside, give location) 6018 Hancock Avenue,	
3. NAME OF DECEASED (Type or print) MARGARET		4. DATE OF DEATH Month Day Year November 1, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) St. Louis, Missouri
13a. FATHER'S NAME John Mc Cullen		14. NAME OF HUSBAND OR WIFE William Bruce Findlay	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give dates of service) No None		16. SOCIAL SECURITY NO. 489-22-1804	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Cervix</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 yr.	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 171x	
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 <i>Jan 1952</i> to <i>Nov 6, 1958</i> and last saw her alive on <i>Oct. 31, 1958</i> Death occurred at <i>4:05 AM</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>M D Johnson M.D.</i>		22b. ADDRESS <i>Ferguson Mo</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11/3/58	
23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri	
25. DATE RECD. BY LOCAL REG. NOV 3 58		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith M.D.</i> S.P.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

signed at De Paul Hospital
Saturday Sure

File in City

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 A. Mlinar*

Licensed Embalmer No. *4186*

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.