

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-041947  
STATE FILE NUMBER  
Registar's No. 10855

FILED NOV 20 1958 Registration District No. 318 Primary Registration District No. 1003

300  
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
26 FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Chronic Hosp.</i>		Length of stay in lb <i>2 1/2 yrs.</i>	d. STREET ADDRESS (If outside, give location) <i>1118 Bayard</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <i>Bertha May</i>			4. DATE OF DEATH Month Day Year <i>11-11-58</i>		
5. SEX <i>female</i>	6. COLOR OR RACE <i>colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-27-1908</i>	9. AGE (In years last birthday) <i>50</i> 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) <i>At home</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>Miss.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>
13a. FATHER'S NAME <i>unk.</i>		13b. MOTHER'S MAIDEN NAME <i>Anna Haynes</i>		14. NAME OF HUSBAND OR WIFE <i>Norman May</i>	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>	16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT <i>4412 DELMAR - NORMAN MAY</i>	Address
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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>Cerebral Thrombosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Cerebral Arteriosclerosis</i>		<i>3 yrs.</i>
	DUE TO (c) <i>Generalized Arteriosclerosis</i>		<i>3 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>332x</i>			19. WAS AUTOPSY PERFORMED? 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.) <i>332x</i>		
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.			

20d. INJURY OCCURRED WHILE AT WORK <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>4-3-56</i> , to <i>11-11-58</i> and last saw <sup>her</sup> him alive on <i>11-11-58</i> Death occurred at <i>1:30 a.m.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <i>John W. Beckham, M.D.</i>	22b. ADDRESS <i>5800 Arsenal</i>	22c. DATE SIGNED <i>11/11/58</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	23b. DATE <i>11-17-58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>WASHINGTON PARK</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis county, MO</i>
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24. FUNERAL DIRECTOR <i>HOWARD &amp; GLENN 4319 DELMAR</i>	25. DATE RECD. BY LOCAL REG. <i>NOV 12 '58</i>	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith m.d.</i>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 K. Cunningham* .....

Licensed Embalmer No. *4476* .....

P. O. Address. *2405 Marcus* .....

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.