Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-042341
STATE FILE NUMBER

FILED DEC 9 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11567

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) ST. LOUIS, MISSOURI — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 04 BARNES HOSPITAL — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE ILLINOIS b. COUNTY MADISON
c. CITY OR TOWN HARTFORD 8129 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 32 15 HAWTHORNE PL. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First IRENE Middle ~~NEW~~ A. Last TEDRICK

4. DATE OF DEATH Month Day Year NOVEMBER 30, 1958

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH SEPT. 27, 1916
9. AGE (In years last birthday) 42 — 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) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) VANDALIA, ILL.
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME IRA SMITH
13b. MOTHER'S MAIDEN NAME RUTH JOLLY
14. NAME OF HUSBAND OR WIFE MYREL TEDRICK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT MYREL TEDRICK Address HARTFORD, ILL.

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 TUBERCULOSIS, QUESTIONABLE ACTIVITY — INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 002 X H
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CARCINOMA OF CERVIX, TREATED
19. WAS AUTOPSY PERFORMED? YES [X] 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. 20, 1958, to NOV. 30, 1958 and last saw her/him alive on NOV. 30, 1958
Death occurred at 8:00 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C. C. Vermillion, M.D. M. D.
22b. ADDRESS BARNES HOSPITAL
22c. DATE SIGNED 12/1/58

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
23b. DATE 12-1-58
23c. NAME OF CEMETERY OR CREMATORY McINTUFF CEMETERY
23d. LOCATION (City, town, or county) (State) FAYETTE Co., ILL.

24. FUNERAL DIRECTOR ADDRESS SMITH FUNERAL HOME, 2521 EDWARDS ALTON, ILL.
25. DATE RECD. BY LOCAL REG. DEC 1 '58
26. REGISTRAR'S SIGNATURE J Earl Smith MD MDB

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 ..... Signed Lawrence E. Meyer not embalme

Signature of Student Embalmer

Licensed Embalmer No. .....

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.