

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-042503

STATE FILE NUMBER

8 / FILED NOV 17 1958

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2845

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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

1. PLACE OF DEATH a. COUNTY St. Louis		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 Clayton		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Ann, 4006
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Co. Hosp. 2 Wks.		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 3611 St. Cosmas
3. NAME OF DECEASED (Type or print) First Pauline Middle M. Last De Woody			4. DATE OF DEATH Month 10 Day 5 Year 58
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 March 25 1921
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assembler		10b. KIND OF BUSINESS OR INDUSTRY Chrom Craft	11. BIRTHPLACE (City and state or country) Texas County Mo.^o
13a. FATHER'S NAME Edward Evans		13b. MOTHER'S MAIDEN NAME Mayde Lynch	14. NAME OF HUSBAND OR WIFE Comer De Woody
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 487-24-2126	17. INFORMANT Address Comer De Woody 3611 St. Cosmas
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO (b) Bronchopneumonia DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Severe cerebral concussion			INTERVAL BETWEEN ONSET AND DEATH
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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 10-23-58 to 11-5-58 and last saw her/him alive on 11-5-58 Death occurred at 5:10 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Vincent J. Redinal M.D.^o		22b. ADDRESS 601 So. Brentwood	22c. DATE SIGNED 11-5-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11/6/58	23c. NAME OF CEMETERY OR CREMATORY Houston Cemetery	23d. LOCATION (City, town, or county) (State) Houston Mo.
24. FUNERAL DIRECTOR ADDRESS Collier Mortuary, St. Ann, Mo.		25. DATE RECD. BY LOCAL REG. 11-5-58	26. REGISTRAR'S SIGNATURE Herbert P. Donke M.D.

gm

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 Sheldon Collins

Licensed Embalmer No. 338
P. O. Address St. Ann

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.