

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-042858

STATE FILE NUMBER

FILED DEC 10 1958 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3141

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Normandy</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Hillsdale #161</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Normandy Osteopathic</u>		Length of stay in lb <u>24 days</u>		d. STREET ADDRESS (If outside, give location) <u>2137 - 67<sup>th</sup> St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marquerite Catherine Mougin</u>				4. DATE OF DEATH Month Day Year <u>11 30 58</u>			
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>w.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 28, 1893</u>		9. AGE (In years last birthday) <u>65</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (City and state or country) <u>Little Rock Ark.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Goe. H. Lex</u>		13b. MOTHER'S MAIDEN NAME <u>Roxie Louisa Kolor</u>		14. NAME OF HUSBAND OR WIFE <u>Frank Roy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>492 24 5544</u>		17. INFORMANT Address <u>Husb. + Daughter 2137 - 67<sup>th</sup> St.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VASO-MOTOR COLLAPSE</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO (c) <u>CORONARY THROMBOSIS 4/201</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Congestive myocardial decompensation</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 minute</u> <u>24 days</u> <u>24 days</u>	
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.)					
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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. Attended the deceased from <u>11-7-58</u> to <u>11-30-58</u> and last saw her/him alive on <u>11-29-58</u> Death occurred at <u>5:30</u> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Robert W. Kelly</u> (Degree or title) <u>DO</u>				22b. ADDRESS <u>2 1917 N. Hanley Rd St. Louis 14</u>		22c. DATE SIGNED <u>11-30-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>12-3-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>		
24. FUNERAL DIRECTOR <u>J.W. Clark F.H. 1125 Hodiamont Ave.</u>				25. DATE RECD. BY LOCAL REG. <u>12-1-58</u>		26. REGISTRAR'S SIGNATURE <u>Herbert R. Donk m</u>	

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 *Alfred J. Boudelier* .....  
Licensed Embalmer No. *2663*  
P. O. Address *1125 1/2 Ave*

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.