

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045765

STATE FILE NUMBER

12109

318

1003

Registrar's No.

FILED DEC 22 1958

Registration District No.

Primary Registration District No.

300
-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 <i>1</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>13 Incarnate Mad 1 wk 2079</i>		Length of stay in lb <i>2079</i>	d. STREET ADDRESS (If outside, give location) <i>5326 Arlington</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Helen</i> Middle <i>Hatchard</i> Last <i>Ulast</i>			4. DATE OF DEATH Month <i>12</i> Day <i>13</i> Year <i>58</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/23/1875</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>self</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>83</i> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) <i>Illinois</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13a. FATHER'S NAME <i>William Stolle</i>		13b. MOTHER'S MAIDEN NAME <i>Don't know</i>	
14. NAME OF HUSBAND OR WIFE <i>George B.</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>—</i>		17. INFORMANT <i>Mr Roy Hatchard 5326 Arlington</i> Address	
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>Chronic myocarditis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Arterial Hypertension</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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>443x</i>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
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>July 1, 1955</i> to <i>December 13, 1958</i> and last saw her ^{her} _{him} alive on <i>December 13, 1958</i> Death occurred at <i>8:30 p.m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Thomas F. Summers, M.D.</i>		22b. ADDRESS <i>5857 Luddell St. Louis 8</i>	
22c. DATE SIGNED <i>12/15/58</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>12/17/58</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Bion Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis County, Mo.</i>	
24. FUNERAL DIRECTOR <i>Joe A. Howard 1619 So. Grand</i>		25. DATE RECD. BY LOCAL REG. <i>DEC 16 '58</i>	
26. REGISTRAR'S SIGNATURE <i>J. Carl Smith MD</i> <i>mon</i>			

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 S. Dennis*
Licensed Embalmer No. *4194*
P. O. Address *St. Louis*

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.