

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002719
State File No.

2 474
Registrar's No.

filed JAN 28 1959

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis State Hospital</u>				STREET ADDRESS (If rural, give location) <u>5100 Arsenal St.</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Velma</u>		b. (Middle) _____		c. (Last) <u>Bedros</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow 2</u>		8. DATE OF BIRTH <u>Oct. 24, 1888</u>	
9. AGE (in years last birthday) <u>70</u>		IF UNDER 1 YEAR Months _____		IF UNDER 1 YEAR Days _____		IF UNDER 24 HRS. Hours _____ Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Charles Willis</u>			13b. MOTHER'S MAIDEN NAME <u>Rachel Hawkins</u>			14. NAME OF HUSBAND OR WIFE <u>Unavailable</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>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>St. Louis State Hospital Records</u>		ADDRESS _____	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial infarction</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>420.0</u> II. OTHER SIGNIFICANT CONDITIONS <u>Bronchopneumonia</u> <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Sept. 26, 1927</u> , to <u>Jan. 13, 1959</u> , that I last saw the deceased alive on <u>Jan. 13, 1959</u> , and that death occurred at <u>9:00 am.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>M. F. Heusley M.D.</u> (Degree or title)				23b. ADDRESS <u>5100 Arsenal St.</u>		23c. DATE SIGNED <u>1-13-59</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>1-14-59</u>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>Tamara, Ill.</u>	
DATE REC'D BY LOCAL REG. <u>JAN 14 59</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u>		ADDRESS <u>4700 Washington Blvd.</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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