

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003158  
STATE FILE NUMBER

2 440  
Registrar's No.

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

**FILED JAN 28 1959**

1. PLACE OF DEATH a. COUNTY <u>City Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>1</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <u>ST LOUIS</u> Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST LOUIS</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CITY HOSPITAL</u> Length of stay in 1b <u>1 da</u>		d. STREET ADDRESS <u>3127 LOCUST</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MOLLIE</u> Middle _____ Last <u>KIRBY</u>			4. DATE OF DEATH Month <u>JAN</u> Day <u>13</u> Year <u>1959</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>UNKNOWN</u>
9. AGE (In years last birthday) <u>87</u>	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) <u>At home</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>UNKNOWN</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>UNKNOWN</u>	14. MOTHER'S MAIDEN NAME <u>UNKNOWN</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 <u>Main Scheimer</u> Address <u>ST LOUIS</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>Chronic Myocarditis</u> <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)		
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 _____ to _____ and last saw her alive on _____ Death occurred at <u>1205 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Schmeier &amp; Doyle</u> (Degree or title) _____		22b. ADDRESS <u>1300 Olive</u>	22c. DATE SIGNED <u>1/14/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>1-15-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT HOPE</u>	23d. LOCATION (City, town, or county) (State) <u>BELLEVILLE ILL</u>
24. FUNERAL DIRECTOR <u>Albert B. Balanus</u> ADDRESS <u>Bellefontaine</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 14 '59</u>	26. REGISTRAR'S SIGNATURE <u>J. Paul Smith, M.D.</u>

Health, Welfare Public Service

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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. Coroner cannot certify to a death due to natural causes.

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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 *Wigil A. Legman*.....  
Licensed Embalmer No. *369*.....  
P. O. Address *Bellville*.....

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.