Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003293
STATE FILE NUMBER

FILED JAN 28 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 198

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 5635 ITASKA — Length of stay in Ib

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY:
c. CITY OR TOWN: ST. LOUIS — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 2149 5635 ITASKA — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First AMELIA Middle Last MOBLEY
4. DATE OF DEATH: Month JAN Day 5 Year 1959
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐
8. DATE OF BIRTH: MARCH 6, 1883
9. AGE (In years last birthday): 75 — 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): AT HOME
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): WELLSVILLE, Mo.
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME: ATWATER ECKLER
13b. MOTHER'S MAIDEN NAME: NOT KNOWN
14. NAME OF HUSBAND OR WIFE: W. PAUL
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 500-26-2916A
17. INFORMANT: KENNETH ECKLER Address: 9549 TESSON FERRY

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Decompensation 1 yr — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Hypertensive Cardio-vascular disease 3 yr
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 443 x
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Dec 1958 to Jan 5 1959 and last saw her alive on Nov 26, 1958
Death occurred at 8 A.M. on the date stated above and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Richard G. Jones MD (Degree or title)
22b. ADDRESS: 3720 Washington
22c. DATE SIGNED: 1-6-59

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: 1/8/1959
23c. NAME OF CEMETERY OR CREMATORY: VALHALLA CEMETERY
23d. LOCATION (City, town, or county) (State): ST. LOUIS Co., Mo.

24. FUNERAL DIRECTOR: J L ZIEGENHEIN & SONS ADDRESS: 7027 GRAVOIS
25. DATE RECD. BY LOCAL REG.: JAN 8 '59
26. REGISTRAR'S SIGNATURE: J. Earl Smith, M.D. M.D.B.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be stated. 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 C. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Gravois

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.