Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003631
STATE FILE NUMBER

FILED JAN 28 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 508

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Missouri Baptist Hospital — Length of stay in Ib

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Reynolds
c. CITY OR TOWN: Black River Twp. — Inside Limits Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location): 8 mi. NW of Black — Reside on Farm Yes [X] No [ ]

3. NAME OF DECEASED (Type or print): First: Dora Middle: Alice Last: White

4. DATE OF DEATH: Month: January Day: 14 Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: March 22, 1879
9. AGE (In years last birthday): 79 — 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and state or country): Reynolds Co., Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME: William Volner
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Hardy White

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.: None
17. INFORMANT: Moses White, 2632 Geyer Ave. Address

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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) Pulmonary tuberculosis — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
C2-X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): arteriosclerotic heart disease.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

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 Sept. 29, 1958 to Jan. 14, 1959 and last saw her/him alive on Jan. 13, 1959
Death occurred at 7:15 am on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Hugo F. Bergman (Degree or title) MD
22b. ADDRESS: 3730 Washington
22c. DATE SIGNED: 1/15/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 1-14-59
23c. NAME OF CEMETERY OR CREMATORY: Meyers Cemetery
23d. LOCATION (City, town, or county) (State): Black, Mo.

24. FUNERAL DIRECTOR: Albert H. Hoppe, ADDRESS: 4700 Washington Blvd.
25. DATE RECD. BY LOCAL REG.: JAN 15 '59
26. REGISTRAR'S SIGNATURE: Carl Smith MD M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 .....

: Licensed Embalmer No. .....

P. O. Address .....

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.