

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003836
STATE FILE NUMBER

FILED FEB 11 1959 Registration District No. 317 Primary Registration District No. 546 Registrar's No. 284

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-57

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Overland		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Overland 4008
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2721 Tennyson		Length of stay in lb years	d. STREET ADDRESS (If outside, give location) 2721 Tennyson
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Lou Cecil	4. DATE OF DEATH Month Day Year January 28, 1959
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1871	9. AGE (In years birthday) 87	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Muscotah, Kansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME William G. Buckles	13b. MOTHER'S MAIDEN NAME Linda Routh	14. NAME OF HUSBAND OR WIFE Frank Cecil, dec'd.
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Chester J. Williams, 2721 Tennyson	Address
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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>Pneumo-pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Var</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Arterio-sclerotic vascular</i>	
	DUE TO (c) <i>degenerate Chr</i>	
PART II. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Fracture left hip 3 months ago. 491XF</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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		
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 *Oct 18th 1958* to *Jan 29 1959* and last saw ^{her}him alive on *Jan 27 1959*
Death occurred at *3:30 A.M.* *3:20* p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>W. Debaugh M.D.</i>	22b. ADDRESS <i>Webster Groves Mo</i>	22c. DATE SIGNED <i>1/29/59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>1-30-1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Lebanon Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Ann, Missouri</i>
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24. FUNERAL DIRECTOR <i>Baumann Bros. Inc. Overland, Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>1-29-59</i>	26. REGISTRAR'S SIGNATURE <i>John C. Murphy, M.D.</i>
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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 *David C. Gibson*

Licensed Embalmer No. *3454*
P. O. Address *Overland 14*

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.