THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003857
STATE FILE NUMBER

FEB 11 1959 Registration District No. 317 Primary Registration District No. 547 Registrar's No. 274

1. PLACE OF DEATH a. COUNTY St.Louis	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St.Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights — Inside Limits Yes X No ☐	c. CITY OR TOWN University City 4346 — Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St.Mary's Hospital — Length of stay in lb 11-days	d. STREET ADDRESS (If outside, give location) 7110a Forsyth Blvd. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)	First: Amedee	Middle: M.	Last: Duford	4. DATE OF DEATH Month Day Year: Jan.28,1959
5. SEX: M.	6. COLOR OR RACE: W.	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED X 2 DIVORCED ☐	8. DATE OF BIRTH: May 25,1863	9. AGE (In years last birthday): 95 — 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): Retired, Foreman, Paper	10b. KIND OF BUSINESS OR INDUSTRY: Mills		11. BIRTHPLACE (City and state or country): Canada 2	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Unk. Duford			14. MOTHER'S MAIDEN NAME: Unknown	
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 Address: Mr.W.J.Duford,7110a Forsyth Blvd.	

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) Rupturing Gall Bladder
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: 10 Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cardio Vascular Lesion 586X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

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 1/10/57, to 1/28-59 and last saw her/him alive on
Death occurred at 8 am. m on the date stated above and to the best of my knowledge, from the causes stated

22a. SIGNATURE (Degree or title): Bruce J Reilly M.D.	22b. ADDRESS: 1/30 Hodiamont	22c. DATE SIGNED: 1-29-59
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal	23b. DATE: Jan.31,1959	23c. NAME OF CEMETERY OR CREMATORY: Niagara Cemetery
23d. LOCATION (City, town, or county) (State): Niagara,Wisconsin		
24. FUNERAL DIRECTOR: Arthur J Donnelly	ADDRESS: 3840 Lindell Blvd.	25. DATE RECD. BY LOCAL REG.: 1-29-59
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 4...

P. O. Address 3840...

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.