

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-006972

STATE FILE NUMBER

2048

Health,  
Welfare  
Public  
Service

FILED MAR 10 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Saint Louis</b>		c. CITY OR TOWN <b>Saint Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>		d. STREET ADDRESS <b>6741 Devonshire</b>	
Length of stay in lb <b>22 days</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>Thomas W Challis Sr.</b>			4. DATE OF DEATH Month <b>Feb</b> Day <b>26</b> Year <b>1959</b>		
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5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-26-1900</b>	9. AGE (In years last birthday) <b>59</b>	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) <b>Claim Representative</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>American Insurance Co., Saint Louis, Missouri</b>	11. BIRTHPLACE (City and state or country) <b>0</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>William Hugh Challis</b>	13b. MOTHER'S MAIDEN NAME <b>Addie M. McGowan</b>	14. NAME OF HUSBAND OR WIFE <b>Marie Challis</b>
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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) <b>No none</b>	16. SOCIAL SECURITY NO. <b>492 05 3072</b>	17. INFORMANT Address <b>Marie Challis 6741 Devonshire St. Louis, Mo</b>
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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) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1-2 yr's</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>GENERALIZED ARTERIOSCLEROSIS</b>		<b>1-2 yr's</b>
	DUE TO (c) <b>ANEURYSM OF ABDOMINAL AORTA</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>443X</b>		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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from <b>1956</b> to <b>FEB 25, 1959</b> and last saw <sup>her</sup> <b>him</b> alive on <b>FEB. 25, 1959</b> Death occurred at <b>12:30 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>Loard Elach, M.D.</b> (Degree or title)	22b. ADDRESS <b>35th Central</b>	22c. DATE SIGNED <b>2-26-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2-28-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	23d. LOCATION (City, town, or country) (State) <b>St. Louis County Missouri</b>
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24. FUNERAL DIRECTOR <b>Hoffmeister Colonial Mortuary</b> <b>6464 Chippewa Street, St. Louis 2, Missouri</b>	25. DATE RECD. BY LOCAL REG. <b>FEB 26 '59</b>	26. REGISTRAR'S SIGNATURE <b>Loard Smith, M.D.</b>
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(Licensee's Embossed Statement on Reverse Side)

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 *Reed C. Branson*

Licensed Embalmer No. *4764*  
P. O. Address *St. Louis*

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.