

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006978

State File No. _____

2 1926

Registrar's No. _____

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). b. STATE <u>MISSOURI</u> c. CITY OR TOWN <u>ST. LOUIS</u> d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>ST. LOUIS</u>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>ST. LOUIS</u>		d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>FIRMIN DESLOGE HOSP.</u>				e. STREET ADDRESS (If rural, give location) <u>2716 50 18 ST.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARY</u> b. (Middle) <u>A</u> c. (Last) <u>Choate.</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 23 1959</u>				
5. SEX <u>PF</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>OCT 30 1896</u>	9. AGE (In years last birthday) <u>62</u>	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 1 MTH. Hours _____ Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SALESLADY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MADEIRA SHOP</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-S-A</u>	
13a. FATHER'S NAME <u>FRANK GEISERT</u>			13b. MOTHER'S MAIDEN NAME <u>AGNES BUESCHER</u>		14. NAME OF HUSBAND OR WIFE <u>FOUNT CHOATE</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>498-16-0818</u>		17. INFORMANT'S SIGNATURE OR NAME <u>FOUNT CHOATE</u>			ADDRESS <u>2716 S 18 ST</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Adenocarcinoma of sigmoid colon</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>generalized metastases.</u> DUE TO (c) <u>153.3</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>	
19a. DATE OF OPERATION <u>Mar. '55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Adenoca. of sigmoid colon.</u>				20. AUTOPSY? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>1-16-1959</u> to <u>2-23-1959</u> , that I last saw the deceased alive on <u>2-23-1959</u> , and that death occurred at <u>12:05 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Edwin C. Smith M.D.</u>			23b. ADDRESS <u>Firmin Desloge Hosp. St. Louis Mo.</u>		23c. DATE SIGNED <u>2/23/59</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>FEB 26 1959</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ST. MATTHEW REM</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>	
DATE RECD BY LOCAL REG. <u>FEB 24 '59</u>		REGISTRAR'S SIGNATURE <u>Edwin C. Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thomas Kutis 2906 Gravois</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10. 48

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0049

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 *Sam C Hill* _____

Licensed Embalmer No. *4347*

P. O. Address *2906 Dan*

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.