

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007194
STATE FILE NUMBER
2 1586

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED MAR 9 1959

1. PLACE OF DEATH a. COUNTY		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 ST LOUIS,		c. CITY OR TOWN NORMANDY 4181	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION CHRISTIAN HOSPITAL		d. STREET ADDRESS (If outside, give location) 8702 LINK	
3. NAME OF DECEASED (Type or print) First Middle Last ANNA MAE HASTING			4. DATE OF DEATH Month Day Year FEB, 13, 1959
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB, 15, 1930
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 28 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
11. BIRTHPLACE (City and state or country) ST LOUIS MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME FRANK HILL		13b. MOTHER'S MAIDEN NAME KATE GROSS	14. NAME OF HUSBAND OR WIFE RAYMOND HASTING
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. #	17. INFORMANT Address RAYMOND HASTING 8702 LINK
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>RESPIRATORY IMPEDIMENT (Block)</u> DUE TO (c) <u>CARCINOMA OF BRONCHI</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Massive pleural effusion</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 Hours</u> <u>72 Hours</u> <u>2 months</u>
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.) <u>162.1</u>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		20f. COUNTY STATE	
21. I attended the deceased from <u>1.13.59</u> to <u>2.13.59</u> and last saw her alive on <u>2.13.59</u> Death occurred at <u>11:13 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Walter H. Redman, M.D.</u>		22b. ADDRESS <u>8307a Jenkins Rd</u>	
22c. DATE SIGNED <u>13 Feb 59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE <u>2/16/59</u>	23c. NAME OF CEMETERY OR CREMATORY ST PETER'S CEMETERY	23d. LOCATION (City, town, or county) (State) ST LOUIS COUNTY MO.
24. FUNERAL DIRECTOR ADDRESS STROOT - CARROLL 4600 NATURAL BRIDGE		25. DATE RECD. BY LOCAL REG. FEB 14 '59	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300
-57

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 *MW Rueter*

Licensed Embalmer No. *4865*
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.