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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007874
STATE FILE NUMBER

FILED MAR 9 1959

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 553

1. PLACE OF DEATH
a. COUNTY: St Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Clayton — Inside Limits: Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St Louis Co Hosp DOA — Length of stay in Hospital: 3

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY: St Louis
c. CITY OR TOWN: Woodson Terrace 4070 — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 9566 Bataan Dr — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: JOANNA Middle: Last: PROST

4. DATE OF DEATH Month Day Year: Feb 27 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 10/25/1880
9. AGE (In years last birthday): 78 — 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (City and state or country): Perry Co Mo
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Lucian Roy
13b. MOTHER'S MAIDEN NAME: Mary Elder
14. NAME OF HUSBAND OR WIFE: Urben N Prost

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: Urben N Prost Address: 9566 Bataan Dr

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): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 443X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Arterial Hypertension. Generalized Arteriosclerosis
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 July 1953 to February 27, 1959 I last saw her/him alive on February 17, 1959.
Death occurred at 11:45 AM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Thomas F. Summers, M.D. (Degree or title)
22b. ADDRESS: 3857 Lindell Blvd. St. Louis
22c. DATE SIGNED: 2-28-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 3/2/59
23c. NAME OF CEMETERY OR CREMATORY: St Marys Cem
23d. LOCATION (City, town, or county) (State): Perryville Mo

24. FUNERAL DIRECTOR: Ortmann Funeral Home ADDRESS: 9222 Lackland Overland Mo
25. DATE RECD. BY LOCAL REG.: 2-28-59
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

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 A. C. Ortmann

Licensed Embalmer No. 3478

P. O. Address .....

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.