

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009957

FILED MAR 19 1959

STATE FILE NUMBER

Registration District No. 160 Primary Registration District No. 5592 Registrar's No. 27

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1. PLACE OF DEATH a. COUNTY <u>Jefferson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Joachim Twp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> <u>2059</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mountain View Conv.</u>		Length of stay in lb <u>Home 1 year</u>	d. STREET ADDRESS (If outside, give location) <u>5858 Nina Place</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Clifton</u> Last <u>Larew</u>	4. DATE OF DEATH Month <u>Mar.</u> Day <u>13</u> Year <u>1959</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 13, 1873</u>	9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u>1</u> Days	IF UNDER 24 HRS. Hours <u>1</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Schoolteacher (Ret)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>St. Louis Public</u>	11. BIRTHPLACE (City and state or country) <u>Maysville, Kentucky</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>William P. Larew</u>	13b. MOTHER'S MAIDEN NAME <u>Eliza Shackelford</u>	14. NAME OF HUSBAND OR WIFE <u>Never married</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Wm. P. Larew, 7562 Wise Pl., St. Louis, Mo.</u> Address
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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) <u>Arteriosclerotic Cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>WORE 1 WH</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4221</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	

20d. INJURY OCCURRED WHILE AT WORK <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 June 3 - 1957 to 3-13-59 and last saw her alive on 3-13-59
Death occurred at 1:20 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>D. H. D. ... M.D.</u> (Degree or title)	22b. ADDRESS <u>Crystal City Mo.</u>	22c. DATE SIGNED <u>3-14-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Mar. 16, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>
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24. FUNERAL DIRECTOR <u>Vinyard Fun'l Homes, Inc., Festus, Mo.</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>3-14-59</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAR - 8 1959

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 W. B. Vinson

Licensed Embalmer No. 4976
P. O. Address Festus, Mo

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.