THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-015663

STATE FILE NO. 2-2866

FILED MAY 1 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St.Louis — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): St.Louis Chronic Hospital — Length of stay in Ib: 50 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 5025 Cabanne — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Mable — Middle: Ann — Last: San-Juan

4. DATE OF DEATH: Month: 3 — Day: 19 — Year: 59

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] **DIVORCED** [ ]

8. DATE OF BIRTH: Nov. 29, 1887

9. AGE (In years last birthday): 71 — 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: At Home

11. BIRTHPLACE (City and state or country): East Bonne Terre, Mo.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: George M. Fraser

13b. MOTHER'S MAIDEN NAME: Margaret Yeager

14. NAME OF HUSBAND OR WIFE: Unavailable

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.: Unknown

17. INFORMANT: Stanley R. Jones, 1112 N. Kingshighway — Address

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) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 1/2 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) 420.0
DUE TO (c) Generalized Arteriosclerosis — 2 1/2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

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 10-4-56, to 3-19-59 and last saw her/him alive on 3-19-59
Death occurred at 12:45 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John W. Beckham, M.D.

22b. ADDRESS: 5800 Arsenal

22c. DATE SIGNED: 3/19/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 3-21-59

23c. NAME OF CEMETERY OR CREMATORY: St.Matthews Cemetery

23d. LOCATION (City, town, or county) (State): St.Louis, Mo.

24. FUNERAL DIRECTOR — ADDRESS: Albert H.Hoppe, 4700 Washington Blvd.

25. DATE RECD. BY LOCAL REG.: MAR 20 '59

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalme

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Melvin L. Kemper

Licensed Embalmer No. 405-2

P. O. Address 494 Washing
St. Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failur 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.