

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016160
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 981

1. PLACE OF DEATH
a. COUNTY St. Louis

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital Length of stay in 1b 2 Weeks

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis

c. CITY OR TOWN Brentwood 4511 Inside Limits Yes No

d. STREET ADDRESS (If outside, give location) 2804 Bremerton Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
MARGUERITE NMI DEMAREE

4. DATE OF DEATH Month Day Year
April 9, 1959

5. SEX F 6. COLOR OR RACE W 7. MARRIED NEVER MARRIED WIDOWED DIVORCED 8. DATE OF BIRTH 12-2-1913 9. AGE (In years last birthday) 45 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) Cartographer 10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't 11. BIRTHPLACE (City and state or country) Portland, Ore. 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Alfy House 13b. MOTHER'S MAIDEN NAME Elizabeth Heinzer 14. NAME OF HUSBAND OR WIFE Francis Demaree

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. unk. 17. INFORMANT Jacqueline Demaree, Address above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Concussion of Pericranium INTERVAL BETWEEN ONSET AND DEATH 15 months
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) 157X 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 Month, Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT 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 Jan 1958 to April 9, 1959 and last saw her alive on April 7, 1959
Death occurred at 6:03 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph P. Coletto D. MD 22b. ADDRESS 4952 Maryland Ave. St. Louis, Mo. 22c. DATE SIGNED 4-10-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 4-11-59 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery 23d. LOCATION (City, town, or county) (State) St. Louis, Mo.

24. FUNERAL DIRECTOR ADDRESS JAY B. SMITH, Maplewood, Mo. 25. DATE RECD. BY LOCAL REG. 4-10-59 26. REGISTRAR'S SIGNATURE John C. Murphy MD

(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.

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 *R. P. Burgess*

Licensed Embalmer No. *4029*
P. O. Address *Maplewood*

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.