

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016285

STATE FILE NUMBER

8 ✓

FILED MAY 7 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1071

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fenton		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Fieser Nursing Home-8Mo.		d. STREET ADDRESS (If outside, give location) 7937 No. Br. Way	
3. NAME OF DECEASED (Type or print) First Alice Middle T Last Flagg		4. DATE OF DEATH Month 4 Day 18 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/4/ 1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and state or country) Ireland
13a. FATHER'S NAME John Broderick		13b. MOTHER'S MAIDEN NAME Johannah Gorman	14. NAME OF HUSBAND OR WIFE unk.
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. None	17. INFORMANT Regina Flagg 7937 No. Br. Way
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>Lobar Pneumonia</u> DUE TO (b) <u>Malnutrition</u> DUE TO (c) <u>Generalized Arteriosclerosis, Arteriosclerotic HD</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized Arteriosclerosis, Arteriosclerotic HD</u>			INTERVAL BETWEEN ONSET AND DEATH 5 days 3 mos
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. Month, Day, Year p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK 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 23, 1958 to 4/18/59 and last saw her alive on 4/15/59 Death occurred at 4/18/59 on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deedee or title) D. R. Nakada		22b. ADDRESS 950 Francis Pl	
22c. DATE SIGNED 4/30/59		22d. DATE SIGNED (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4/22/59	
23c. NAME OF CEMETERY OR CREMATORY Calvary		23d. LOCATION (City, town, or county) St. Louis Mo.	
24. FUNERAL DIRECTOR Leaff Linder Fenton Mo.		25. DATE RECD. BY LOCAL REG. 4-20-59	
26. REGISTRAR'S SIGNATURE John C. Murphy, MD		27. REGISTRAR'S SIGNATURE	

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No. 4975

P. O. Address Del Rio, Tex.

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.