

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022796

FILED JUL 13 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar No. **2 6157**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 4-N KINGSHIGHWAY		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 4 N. Kingshighway Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last CORNELIA SOUTHER CRAIG			4. DATE OF DEATH Month Day Year June 29, 1959			
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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 Sept. 2 1865	9. AGE (In years last birthday) 93	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and state or country) St. Louis Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME EUSTACE E. SOUTHER	13b. MOTHER'S MAIDEN NAME CORNELIA CASTERLINE	14. NAME OF HUSBAND OR WIFE DR. THOMAS CRAIG
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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) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Miss Edith E. Souther	Address 4-No Kingshighway
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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) Arterio-sclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 24 HRS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) general arterio-sclerosis	
	DUE TO (c) 420.0	
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 <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.)
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20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT <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 Feb 1940 to June 29 1959 Death occurred at 3:05 am on the date stated above; and to the best of my knowledge, from the causes stated.		21b. I last saw her alive on June 28 1959
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22a. SIGNATURE (Degree or title) Samuel B Grant M.D.	22b. ADDRESS 114 N Taylor Ave	22c. DATE SIGNED 6/29/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JULY 1-1959	23c. NAME OF CEMETERY OR CREMATORY BELLEFONTAINE CEM.	23d. LOCATION (City, town, or county) (State) ST. LOUIS MISSOURI
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24. FUNERAL DIRECTOR C.R. Lupton & Sons	ADDRESS 7233 Delmar Blvd	25. DATE RECD. BY LOCAL REG. JUN 30 '59	26. REGISTRAR'S SIGNATURE Loam Smith, M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Any diseases in Part I must be causally related.

JUL 20 1959

JUL 21 1959

VS SEP 1 1960

Dr. Sam Grant
114 N. Taylor
JE 3-8600

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 ... *Arnold W. Schoen* ...

Licensed Embalmer No. *3864*

P. O. Address *St. Louis, 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.