

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022975

STATE FILE NUMBER

Registration No. 5519

FILED JUN 18 1959

Registration District No. Primary Registration District No.

1. PLACE OF DEATH a. COUNTY		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 St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4152 Botanical Ave.		Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 4152 Botanical Ave.	
				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First MAY			Month Day Year June 6 1959		
Middle HEDRIQUE					
Last					

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1879	9. AGE (In years last birthday) 80	10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician-Mohler College	10b. KIND OF BUSINESS OR INDUSTRY College	11. BIRTHPLACE (City and state or country) Farmington, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Unknown Hedrique	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE -----
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) None	16. SOCIAL SECURITY NO. ---	17. INFORMANT Address F. W. Agney 4015 Magnolia Pl.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) IMMEDIATE CAUSE (a) Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH few minutes
DUE TO (b) Hypertensive cardiovascular disease		
DUE TO (c) Generalized arteriosclerosis		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (If not related to the terminal disease condition given in PART I (a)) 420.1		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 Month, Day, Year 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 Death occurred at 8:00 P. on 8-14-46 to 6-6-59 and last saw her/him alive on 10-7-58

22a. SIGNATURE E. M. Charles (Degree or title)	22b. ADDRESS 110 S. Central Clayton 5th	22c. DATE SIGNED 6-9-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE June 10, 1959	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	23d. LOCATION (City, town, or county) St. Louis Co. Mo.	(State)
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24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway	25. DATE RECD. BY LOCAL REG. JUN 9 '59	26. REGISTRAR'S SIGNATURE Earl Smith M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

ALL DISSEASERS IN Part I must be causally related.

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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 *Richard W. Storvick*

Licensed Embalmer No. *4007*.....

P. O. Address

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.