

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023354

STATE FILE NUMBER

2-5198

FILED JUN 19 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

Health,
Welfare
Public
Service

300
1-56
32
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4376
6
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis			
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 University City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital			Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 7536 Gannon Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Bessie Achuff Rowe				4. DATE OF DEATH Month Day Year May 29, 1959			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 22, 1903		9. AGE (In years just birthday) 56	
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 Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Dick Achuff				14. MOTHER'S MAIDEN NAME Emma Haid			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. James H. Rowe 7536 Gannon Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myelocytic leukemia						INTERVAL BETWEEN ONSET AND DEATH 11 mos.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						2043	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute cerebral hemorrhage						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) None					
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	
21. I attended the deceased from June 1958, to May 29, 1959 and last saw her alive on May 29, 1959 Death occurred at 2:30 A m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Herbert C. Wigand, M.D.				22b. ADDRESS 3720 Washington		22c. DATE SIGNED May 29, 1959	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6/1/1959	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County Missouri.		
24. FUNERAL DIRECTOR C.R. Lypton and Sons 7233 Delmar				25. DATE RECD. BY LOCAL REG. 5-30-59		26. REGISTRAR'S SIGNATURE Kearl Smith, M.D.	

(Licensed Embalmer's Statement on Reverse Side)

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Use Thursday 2.77.

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. *388*

P. O. Address *St. Louis*

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.