

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023654  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1677

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hosp.</b>		Length of stay in lb <b>days</b>	d. STREET ADDRESS <b>2523 Minnesota</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>MURRELL LASTER</b>			4. DATE OF DEATH Month Day Year <b>June 21, 1959</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 10, 1920</b>	9. AGE (In years last birthday) <b>39</b>	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) <b>DeCaler</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Int. Nat. Shoe Co.</b>	11. BIRTHPLACE (City and state or country) <b>East Prairie, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Frank Manning</b>	13b. MOTHER'S MAIDEN NAME <b>Bertha Manning</b>	14. NAME OF HUSBAND OR WIFE <b>Argie Laster</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>490-20-7573</b>	17. INFORMANT <b>Argie Laster, St. Louis, Mo.</b>
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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) <b>Sub-arachnoid Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 Min</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>?</b> DUE TO (c) <b>330 X</b>		
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.) <b>?</b>
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/> WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK	20f. CITY, TOWN, OR LOCATION <b>East Prairie, Mo.</b>	COUNTY <b>East Prairie, Mo.</b>	STATE
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21. I attended the deceased from <b>6/21/59</b> to <b>6/21/59</b> and last saw her alive on <b>6/24/59</b> Death occurred at <b>9/15 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>John C. Murphy, M.D.</b>	22b. ADDRESS <b>730 Hadament</b>	22c. DATE SIGNED <b>6-22-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>6-21-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>	23d. LOCATION (City, town, or county) (State) <b>East Prairie, Mo.</b>
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24. FUNERAL DIRECTOR <b>McMikel, East Prairie, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>6-23-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy, M.D.</b>
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Health, Welfare, Public Service

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

P.S. V. Riley Hadament  
730 Hadament  
JUL 15 1959 9:40 am

**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 *Clarence M. Belts* .....

Licensed Embalmer No. *4325* .....  
*St. Louis 23 MO.*  
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.