

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026947

FILED VS AUG 5 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's **2 6885** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>		Length of stay in 1b <u>7 Days</u>	c. CITY OR TOWN <u>St. Louis.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lutheran Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6237 Odell</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>Mary</u>	Middle <u>Etta</u>	Last <u>Merritt</u>	4. DATE OF DEATH	Month <u>July</u>	Day <u>24</u>	Year <u>1959</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/24/1884</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
				Months	Days	Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Falkner, Miss.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>George Pasuer</u>	13b. MOTHER'S MAIDEN NAME <u>Ollie Stewart</u>	14. NAME OF HUSBAND OR WIFE <u>Wm. P. Merritt</u>
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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) <u>No.</u>	16. SOCIAL SECURITY NO. <u>Nil.</u>	17. INFORMANT <u>Virginia O'Connell, 6237 Odell, Ave.</u>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u>		<u>6 DAYS</u>
Conditions, if any, which gave rise to above cause (b), stating the underlying cause last.	DUE TO (b) <u>CORONARY OCCLUSION</u>	<u>6 DAYS</u>
	DUE TO (c) <u>ARTERIOSCLEROSIS</u>	<u>?</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>UREMIA - ARTERIOSCLEROTIC HEART DISEASE</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.) <u>420.1</u>
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		

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 9/7/59 to 9/24/59 and last saw her alive on 7/23/59
Death occurred at 2:15 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>August V. Hruschel M.D.</u>	(Degree or title)	22b. ADDRESS <u>4401 Hampton Ave</u>	22c. DATE SIGNED <u>7/24/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>7-27-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Local Cemetery</u>	23d. LOCATION (City, town, or county) <u>Blytheville, Arkansas</u>
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24. FUNERAL DIRECTOR <u>Albert H. Hoppe Inc., 4700 Washington, Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>JUN 24 '59</u>	26. REGISTRAR'S SIGNATURE <u>Leon Smith, M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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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 _____ or by _____, Student, Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Stanley H. Aifon

Licensed Embalmer No. 4193

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.