

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030538

FILED VS AUG 24 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2-7466** STATE FILE NUMBER

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		Length of stay in 1b	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 St. Louis-Little Rock Hosp Inc.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5600 Pernod Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Minnie Middle ROSE- Last Kidd			4. DATE OF DEATH Month August Day 10 Year 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 BIRT. 9-15-1891	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and state or country) ST LOUIS, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME CHARLES WILH		13b. MOTHER'S MAIDEN NAME CATHERINE EHLER		14. NAME OF HUSBAND OR WIFE Walter M. Kidd	
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.	17. INFORMANT Address WALTER M. KIDD - 5600 PERNOD		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c) Carcinoma Cerebri	6 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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

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.)	
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

21. I attended the deceased from **July 14, 1959** to **August 10, 1959** and last saw her ^{her} _{him} **August 10, 1959**
Death occurred at **11:40 A** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) R. Enclosure M.D.		22b. ADDRESS 1755 S. Grand Blvd.		22c. DATE SIGNED 8/10/59 (State) Mo.
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 8-13-1959	23c. NAME OF CEMETERY OR CREMATORY NEW ST MARCUS	23d. LOCATION (City, town, or county) ST LOUIS CO.	
24. FUNERAL DIRECTOR ADDRESS Kreighshauer Funeral Home, St. Louis, Mo		25. DATE RECD. BY LOCAL REG. AUG 1 1959	26. REGISTRAR'S SIGNATURE Earl Smith. M.D.	

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

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 William B. White

Licensed Embalmer No. 4291

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.