

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030606

FILED VS SEP 1 1959

2 7523

STATE FILE NUMBER

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

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</u>		Length of stay in 1b		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>Incarinate Word</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3409 California Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Mattie</u> Middle <u>Mc Faul</u> Last <u>Mc Faul</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>11</u> Year <u>1959</u>						
5. SEX <u>F</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>4-4-1974</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 62 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Jacob Knicley</u>			13b. MOTHER'S MAIDEN NAME <u>Amanda Shumate</u>			14. NAME OF HUSBAND OR WIFE <u>Chas. W. Mc Faul</u>			
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>492-24-4392</u>		17. INFORMANT <u>Naud S. Cook</u> Address <u>Staunton Va</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General peritonitis</u> <u>old walled-off retrocecal abscess</u> DUE TO (b) <u>old walled-off retrocecal abscess</u> DUE TO (c) <u>appendicitis 550.1</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>arteriosclerosis, cardiac vascular disease, chronic coronary artery 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			
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 <u>8-7-59</u> to <u>8-11-59</u> and last saw her alive on <u>8-11-59</u> Death occurred at <u>10:55 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Walter E. Abell</u> (Degree or title) <u>M.D.</u>			22b. ADDRESS <u>2253 So. 10th St.</u>			22c. DATE SIGNED <u>8-12-59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-14-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New St. Marcus</u>		23d. LOCATION (City, town, or county) (State) <u>4700 St. Charles Ave.</u>			
24. FUNERAL DIRECTOR <u>Bisgenheim Bros</u>			ADDRESS <u>-6409 Gravois</u>		25. DATE RECD. BY LOCAL REG. <u>AUG 13 59</u>		26. REG. SIGNATURE <u>Carl Smith. M.D.</u>		

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

Law M. Seymour

Licensed Embalmer No. 4343

P. O. Address St. Louis, Mo

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.