

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS SEP 1 1959**

**59-030689**

**2 7759**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Louis</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY _____			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>12/4/54</b>		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>Masonic Home of Missouri</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>5381 Delmar Blvd</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Anna</b> Middle <b>J.</b> Last <b>Pavey</b>				<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>20</b> Year <b>1959</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>11/27/1876</b>	
				<b>9. AGE (last birthday)</b> <b>82</b>		<b>IF UNDER 1 YEAR</b> Months _____ Days _____	
				<b>IF UNDER 24 HR</b> Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Brighton, Ill.</b>	
						<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>	
<b>13a. FATHER'S NAME</b> <b>Philpp. W. Minor</b>				<b>13b. MOTHER'S MAIDEN NAME</b> <b>Anna Maria Kaiser</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Reuben W. Pavey</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>Mr Lewis Robertson 5351 Delmar Blvd</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis 24 hours</b> (b) <b>Generalized Arteriosclerosis</b> (c) <b>420.1</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>24 hour</b> Unknown
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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE	
<b>21. I attended the deceased from</b> <b>8/12/59</b> to <b>8/19/59</b> and last saw her/him alive on <b>8/19/59</b> Death occurred at <b>12:00 Noon</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <b>Harold E. Walters M.D.</b>				<b>22b. ADDRESS</b> <b>3720 Washington St. Louis Mo.</b>		<b>22c. DATE SIGNED</b> <b>8-21-59</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE</b> <b>8/21/59</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Bellefontaine Cemetery St. Louis, Missouri</b>		<b>23d. LOCATION</b> (City, town, or county) (State)	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Alexander and Sons 6175 Delmar Bl</b>				<b>25. DATE RECD. BY LOCAL REG.</b> <b>AUG 2 1959</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Keal Smith M.D.</b>	

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 W E Morris

Licensed Embalmer No. 336  
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.