

Health,
& Welfare
Public
Service

S. 300
v. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-031170

STATE FILE NUMBER

FILED VS AUG 19 1959

Registration District No. 325 Primary Registration District No. 6099 Registrar's No. 28

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Platteville</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		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			Length of stay in 1b <u>10 days</u>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Evelyn</u> Middle <u>Ann</u> Last <u>Saul</u>						4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>'59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 5 - 1892</u>		9. AGE (In years last birthday) <u>67</u> IF UNDER 1 YEAR: Months <u>6</u> Days <u>7</u> IF UNDER 24 HRS.: Hours <u>6</u> Min. <u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Greenport Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Henry Schree</u>				13b. MOTHER'S MAIDEN NAME <u>Margaret Pucis</u>		14. NAME OF HUSBAND OR WIFE <u>Raymond Saul</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>489-421275</u>		17. INFORMANT <u>Blissie Johnson (w/ 10/6/59)</u> Address			
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>Cerebral thrombus</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertension</u>								INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>10 yrs.</u> <u>10 yrs.</u>	
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>-</u>						
20c. TIME OF INJURY Hour <u>-</u> Month <u>-</u> Day <u>-</u> Year <u>-</u> a.m. <u>-</u> p.m. <u>-</u>			20d. INJURY OCCURRED WHILE AT <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.) <u>-</u>			20f. CITY, TOWN, OR LOCATION		COUNTY		STATE		
21. I attended the deceased from <u>8/23/50</u> to <u>8/28/59</u> and last saw her alive on <u>8/28/59</u> Death occurred at <u>2:30</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Edward M. Roberts M.D.</u>				22b. ADDRESS <u>Queen City Mo.</u>			22c. DATE SIGNED <u>6/28/59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>June 30 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Queen City Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Queen City Mo.</u>			
24. FUNERAL DIRECTOR <u>Jack & Dorothy ...</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>8-10-59</u>		26. REGISTRAR'S SIGNATURE <u>W. W. Drake</u>		

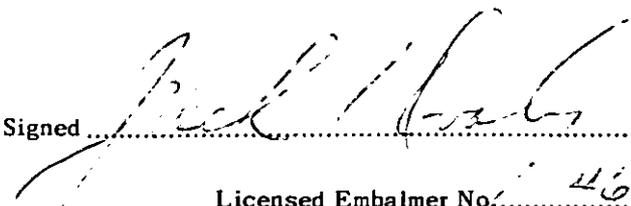
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 

Licensed Embalmer No. 4617
P. O. Address Quevedo City

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.