

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033529

FILED VS SEP 16 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **8154** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>			Length of stay in 1b		c. CITY OR TOWN <b>ST. LOUIS</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>DEACONESS HOSP.</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1956 SIDNEY</b>
3. NAME OF DECEASED (Type or print) First <b>MAMIE</b> Middle _____ Last <b>AYERS</b>			4. DATE OF DEATH Month <b>AUG</b> Day <b>31</b> Year <b>1959</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8-31-1892</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
13a. FATHER'S NAME <b>SAMUEL POWELL</b>		13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT <b>NORMA ZIEBA</b> Address <b>1956<sup>e</sup> SIDNEY</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b>					INTERVAL BETWEEN ONSET AND DEATH <b>24 Hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic myocarditis &amp; hypertension</b>					Year
DUE TO (c) <b>443x</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Atypical pneumonia left lobe</b>					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 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.)	
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 <b>4-9-51</b> to <b>8-31-59</b> and last saw her alive on <b>8-31-59</b> Death occurred at <b>12:05 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Arnold G. Lem</i> (Degree or title)			22b. ADDRESS <b>2632 S Kings Highway</b>		22c. DATE SIGNED <b>9-1-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>SEPT 3, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL CCM.</b>		23d. LOCATION (City, town, or county) <b>JEFFERSON BRKS. MO.</b>	
24. FUNERAL DIRECTOR <b>Thomas Lutz</b> ADDRESS <b>2906 Gravois</b>		25. DATE RECD. BY LOCAL REG. <b>SEP 2 1959</b>		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

11-330 12/11/94

**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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 Grav

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.