

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-034805

FILED VS SEP 21 1959

Registration District No. 317 Primary Registration District No. 500 STATE FILE NUMBER Registrar's No. 2378

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| 1. PLACE OF DEATH a. COUNTY Saint Louis | | 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 Normandy | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Saint 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 Normandy Osteopathic | | Length of stay in lb 6 days | d. STREET ADDRESS (If outside, give location) 3006 N. Prairie Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Amanda Middle Last Little | | | 4. DATE OF DEATH Month Sept. Day 2 Year 1959 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 3, 1881 |
| 9. AGE (In years last birthday) 78 | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Tyler, Missouri |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13a. FATHER'S NAME unknown | |
| 13b. MOTHER'S MAIDEN NAME unknown | | 14. NAME OF HUSBAND OR WIFE unknown | |
| 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. unknown | 17. INFORMANT Katherine Pott 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) CEREBRAL THROMBOSIS DUE TO (b) ARTERIAL SCLEROSIS DUE TO (c) 30 2XF Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) FRACTURE OF RIGHT FEMUR | | | INTERVAL BETWEEN ONSET AND DEATH 10 YRS |
| 20a. ACCIDENT <input checked="" 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.) FALL AT HOME DOWN STEPS | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. 4:27 p.m. 1959 | | 20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME | |
| 20e. CITY, TOWN, OR LOCATION ST. LOUIS | | COUNTY STATE | |
| 20f. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | |
| 21. I attended the deceased from Aug 27 1959 to Sept 2, 1959 and last saw her alive on Sept 2, 1959 Death occurred at 3:34 PM m of the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE W F Lubbert (Degree or title) | | 22b. ADDRESS 917 Airport Rd, St Louis 35 Mo | 22c. DATE SIGNED Sept 4, 1959 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 9-5-59 | 23c. NAME OF CEMETERY OR CREMATORY Local |
| 23d. LOCATION (City, town, or county) Cape Girardeau, Mo. | | (State) | |
| 24. FUNERAL DIRECTOR Albert H. Hoppe Inc., 4700 Washington, | | 25. DATE RECD. BY LOCAL REG. 9-5-59 | 26. REGISTRAR'S SIGNATURE J. C. Murphy M.D. |

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

SEP 21 1959

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 *Lawrence O. Gerking*

Licensed Embalmer No. *4979*
P. O. Address *St. Louis, Mo.*

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.