

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038415

FILED/V.S. NOV 16 1959 317

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2868 STATE FILE NUMBER

| | | | | | |
|---|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Valley Park</u> | | Length of stay in 1b <u>9 months</u> | c. CITY OR TOWN <u>Clayton</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>Moll Nursing Home</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>832 N. Biltmore</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>ASTON</u> Last <u>ASTON</u> | | | 4. DATE OF DEATH Month <u>October</u> Day <u>28</u> Year <u>1959</u> | | |
| 5. SEX <u>Female</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>7/6/78</u> | 9. AGE (last birthday) <u>81</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | 11. BIRTHPLACE (City and state or country) <u>North Ireland</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>Harry Anderson</u> | | 13b. MOTHER'S MAIDEN NAME <u>Rachel Pedlow</u> | | 14. NAME OF HUSBAND OR WIFE <u>James Aston</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>None</u> | 17. INFORMANT Address <u>Clayton, Mo.</u> <u>Mrs. Florence A. Jefferson, 832 N. Biltmore</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>Cerebral Hemorrhage</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized arteriosclerosis</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 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 <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u> | | | | | |
| 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>1-15-59</u> to <u>10-28-59</u> and last saw her alive on <u>10/27/59</u> Death occurred at <u>10:5 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> (Degree or title) | | | 22b. ADDRESS <u>Kirkwood St. Mo.</u> | | 22c. DATE SIGNED <u>10/28/59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>10/29/59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u> | | 23d. LOCATION (City, town, or county) <u>Arlington, N. J.</u> | |
| 24. FUNERAL DIRECTOR <u>Louis H. Boyd Inc. Kirkwood</u> | | ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>10-29-59</u> | 26. REGISTRAR'S SIGNATURE <u>John C. Murphy, 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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Fernando J. Wyland Jr.*

Licensed Embalmer No. 4512

P. O. Address Richmond, Va.

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.