

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

FILED NOV 16 1959

59-038460

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2869

INDEXED

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>Affton</u>		Length of stay in 1b <u>1 YR.</u>	c. CITY OR TOWN <u>Affton</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>8018 Laclede Station Rd.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>8018 Laclede Station Rd</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jeanne</u> Middle <u>Marie</u> Last <u>Cashion</u>			4. DATE OF DEATH Month <u>Oct</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 checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/30/1958</u>	9. AGE (last birthday) <u>1</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)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Louis Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Bruce Cashion</u>		13b. MOTHER'S MAIDEN NAME <u>Ruth Lohbeck</u>		14. NAME OF HUSBAND OR WIFE <u>-----</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>Bruce Cashion 8018 Laclede Station Rd.</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>Bronchopneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>PULMONARY Fibrosis</u> DUE TO (c) <u>FIBROCYSTIC DISEASE OF PANCREAS</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>with to date.</u>	
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 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> 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>Birth 6/30/58</u> to <u>10/28/59</u> and last saw her <u>alive on 10-23-59</u> Death occurred at <u>6:00P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>J.C. Kaudon M.D.</u> (Degree or title)			22b. ADDRESS <u>950 Francis Pl Clayton St</u>		22c. DATE SIGNED <u>10/29</u> (State)	
23a. BURIAL CREMATION REMOVAL (Specify) <u>burial</u>	23b. DATE <u>10/30/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lakewood Park Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis Co., Mo.</u>		
24. FUNERAL DIRECTOR <u>John L Ziegenhein &amp; Sons 7027 Gravois</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>10-29-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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 Donald Benz

Licensed Embalmer No. 4863

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.