

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
FILED VS DEC 11 1959

59-041946

211110

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

ENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>14 Yr's.</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>4617 Maryland Ave.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4617 Maryland Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SARAH Washington HIESTAN</b>				4. DATE OF DEATH Month Day Year <b>Nov. 30, 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>1/20/70</b>	9. AGE (last birthday) <b>89</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home Maker</b>		11. BIRTHPLACE (City and state or country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Edmund Coleman</b>			13b. MOTHER'S MAIDEN NAME <b>Mathilda Patterson</b>			14. NAME OF HUSBAND OR WIFE <b>Oliver Hiestan</b>		
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>none</b>		17. INFORMANT Address <b>Ruby Higgins 4617 Maryland Ave.</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>embolus left brachial artery</b>							INTERVAL BETWEEN ONSET AND DEATH <b>24 hr</b>	
DUE TO (b) <b>embolus mesenteric artery</b>								
DUE TO (c) <b>arteriosclerotic heart infarctus</b>							<b>3 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>pancreatitis chronic</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 s.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>March 1955</b> to <b>Nov. 30, 1959</b> and last saw her alive on <b>11-29-59</b> Death occurred at <b>3:30 AM 11-30-59</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Dominic J. Verda M.D.</b>				22b. ADDRESS <b>4500 Olive St</b>			22c. DATE SIGNED <b>11-30-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Dec. 2, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hiram Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis County</b>		STATE <b>Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Cullen Kelly 7267 Natural Bridge</b>			25. DATE RECD. BY LOCAL REG. <b>DEC 1 1959</b>		26. REGISTRAR'S SIGNATURE <b>Paul Smith, M.D.</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

mjb

**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

*James G. Lawrence*

Licensed Embalmer No. 4142

P. O. Address St. Louis

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.