

MORTUARY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 3 0 1959

'59 0 4 5 5 1 3

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's **211212**

MAILED

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| 1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis c. CITY OR TOWN Richmond Heights Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 1177 Moorlands Dr. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
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| 3. NAME OF DECEASED (Type or print) First VERA Middle MILDRED Last HARGATE | | | 4. DATE OF DEATH Month December Day 2 Year 1959 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH Mar. 30, 1899 | 9. AGE (last birthday) 60 | IF UNDER 1 YEAR Months 8 Days 2 Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | | |
| 13a. FATHER'S NAME Edward Patrick Powers | | 13b. MOTHER'S MAIDEN NAME Rose B. Chevraux | | 14. NAME OF HUSBAND OR WIFE Hubbard C. Hargate | | |
| 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. | | 17. INFORMANT Address Hubbard Hargate, 1177 Moorlands Dr. | | |

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| 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 Vascular Accident DUE TO (b) arteriosclerosis DUE TO (c) 331x Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) - Rheumatic Heart Disease with Congestive Heart Failure | | |

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| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 11-20-52 to **Dec. 2, 1959** and last saw her ~~alive~~ ^{her} **Dec. 2, 1959**
 Death occurred at 7:25 **A** m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) Ernest H. Scheyer, M.D. | 22b. ADDRESS 7200 Manchester | 22c. DATE SIGNED 12/2/59 |
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|---|---|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Dec. 4, 1959 | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis, Missouri |
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| 24. FUNERAL DIRECTOR ADDRESS Ambruster Mortuary, 6633 Clayton Rd. | 25. DATE RECD. BY LOCAL REG. DEC 3 1959 | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

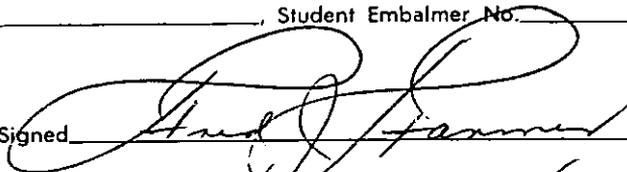
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 4788

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.