

1. PLACE OF DEATH a. COUNTY		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 St. Louis, Mo.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Firmin Desloge Hospital		d. STREET ADDRESS (If outside, give location) 2923 Eads Ave.	

3. NAME OF DECEASED (Type or print) First Polly Middle A. Last POSTON			4. DATE OF DEATH Month Nov Day 22 Year 1960		
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-20-1883	9. AGE (last birthday) 77	IF UNDER 1 YEAR Months Days 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		11. BIRTHPLACE (City and state or country) Dasy, Missouri	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Habs Ransom		13b. MOTHER'S MAIDEN NAME Catherine Dismande	
14. NAME OF HUSBAND OR WIFE William		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. None	
17. INFORMANT Mr. Lee Poston		Address 2923 Eads Ave.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH 12 days
IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Chronic Brain Syndrome - due to Arteriosclerosis		
	DUE TO (c) 450.0		

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		
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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 Month, Day, Year a.m. p.m.					
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 November 11, 1960 to Nov 22, 1960 and last saw her alive on Nov 21, 1960 Death occurred at 7:25 A m on the date stated above, and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE (Degree or title) William M Fogarty Jr M.D.			22b. ADDRESS 1325 So Grand, St Louis		22c. DATE SIGNED 11/22/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-22-60	23c. NAME OF CEMETERY OR CREMATORY Barks Chapel Cemetery		23d. LOCATION (City, town, or county) (State) White Water Missouri	
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc. 4700 Washington			25. DATE RECD. BY LOCAL REG. NOV 22 1960		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John J. Haines

Licensed Embalmer No. 4108

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.