

FILED OCT 25 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35073

State File No.

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6073 Registrar's No. 319

1. PLACE OF DEATH a. COUNTY <u>ST. FRANCOIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. FRANCOIS</u>	
b. CITY OR TOWN <u>BONNE TERRE</u> (If outside corporate limits, write RURAL and give township) <u>Rural</u>		c. CITY OR TOWN <u>BONNE TERRE</u> (If outside corporate limits, write RURAL and give township) <u>0940</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>RURAL-ROUTE 2, BONNE-TERRE</u>		d. STREET ADDRESS (If rural, give location) <u>RURAL-ROUTE 2, BONNE TERRE,</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>CARRIE</u> b. (Middle) <u>ADELINE</u> c. (Last) <u>STEINMETZ</u>			4. DATE OF DEATH a. (Month) <u>OCT</u> (Day) <u>14</u> (Year) <u>1954</u>		
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, <u>9</u> WIDOWED, DIVORCED (Specify)	
8. DATE OF BIRTH <u>Aug 26 - 1880</u>		9. AGE (In years last birthday) <u>74</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>18</u> IF UNDER 12 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VALLEY MINES, MISSOURI</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>SAMUEL KELLEY</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH-HAVERSTICK-HARRY-STEINMETZ</u>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>CLINTON FRANCOIS STEINMETZ, B.T.</u>		ADDRESS <u>MO.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5-years-1</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenic, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5-years-1</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>General arteriosclerosis</u>		DUE TO (c)		unknown	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 10/15/53, 1953, to 10/13/54, 1954, that I last saw the deceased alive on 10/13/54, 1954, and that death occurred at 4:30 pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Jack Whitten M.D.</u>		23b. ADDRESS <u>Bonne Terre, Mo.</u>		23c. DATE SIGNED <u>10/18/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>OCT. 17 - 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>BONNE-TERRE CEM.</u>	
24d. LOCATION (City, town, or county) (State) <u>BONNE TERRE, MO.</u>					

DATE REC'D BY LOCAL REG. <u>Oct 18, 1954</u>		REGISTRAR'S SIGNATURE <u>289</u> <u>Ethel Rudolph</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Everett Sparks</u> ADDRESS <u>Mo.</u>	
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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
Student Embalmer

Signed

Everett Park

Licensed Embalmer No. _____

4287

P. O. Address _____

Flat River

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.