

MAY 15 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13314

State File No.

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 3516

1. PLACE OF DEATH:

- (a) County St. Louis
 (b) City or town St. Louis
 (c) Name of hospital or institution: 1311 Russell
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community _____ years, months or days)

3. (a) PRINT FULL NAME

Lila M. Crea

3. (b) If veteran, name war
- nil.

8. (c) Social Security No.
- nil

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced widowed
 6. (b) Name of husband or wife John 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased May 5 1865
 (Month) (Day) (Year)

8. AGE: Years
- 74
- Months
- 11
- Days
- 11
- If less than one day _____ hr. _____ min.

9. Birthplace
- St. Louis Mo.
-
- (City, town, or county) (State or foreign country)

10. Usual occupation
- Housewife

11. Industry or business

12. Name John Paille
 13. Birthplace England
 (City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace England
 (City, town, or county) (State or foreign country)

16. (a) Informant Matthew M. Dea
 (b) Address 1311 Russell
 17. (a) Burial (b) Date thereof 4 19 40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Ouluany
 18. (a) Signature of funeral director W. B. Groves
 (b) Address 4257 Euclid
 19. (a) APR 18 1940
 (Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo. (b) County _____
 (c) City or town St. Louis 23
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1311 Russell
 (If rural, give location)

- (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- 4
- day
- 16
-
- year
- 1940
- hour
- 11:30
- minute
- a
- M.

21. I hereby certify that I attended the deceased from
- 4-5-
-
- _____, 19
- 40
- , to
- 4-16
- , 19
- 40

that I last saw her alive on 4-15-40, 1940; and that death occurred on the date and hour stated above.Immediate cause of death Chronic myocarditis with cardiac vascular renal syndrome

Due to _____

Due to _____

Other conditions Hypertension
(Include pregnancy within 3 months of death)Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature
- W. B. Groves
- (M. D. or other) _____
-
- Address
- 1080 Euclid
- Date signed
- 4/18/40

Duration several monthsseveral years

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

JUL 16 1941

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Howard L. Paul*

Licensed Embalmer No. *3114*

P. O. Address.....

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 this body is not embalmed, above space should be left blank.