

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

**FILED** OCT 25 1945  
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 8905

1. PLACE OF DEATH:

(a) County .....  
 (b) City or town ST. LOUIS MO.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
CITY ISOLATION HOSPITAL. 0  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 10/13/45 to 11/25/45 to  
(Specify whether)  
 In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County \_\_\_\_\_  
 (c) City or town ST. LOUIS MO.  
(If outside city or town limits, write "RURAL" and name of township)  
 (d) Street No. 5800 ARSENAL ST.  
3805 Kosciuszko  
(If rural, give location)  
 (e) Citizen of foreign country? NO. (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME LULA GARLAND.  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 13  
 year 1945 hour 5:50 minute \_\_\_\_\_ A. M.  
 21. I hereby certify that I attended the deceased from 4/25  
 19 45 to 10/13 19 45  
 that I last saw h. er alive on 10/13 19 45  
 and that death occurred on the date and hour stated above.

4. Sex FEMALE / 5. Color or race WHITE  
 6. (a) Single, widowed, married, divorced WIDOW   
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

Immediate cause of death \_\_\_\_\_  
Hypertensive heart disease  
 Due to Cerebral Arteriosclerosis  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

7. Birth date of deceased SEPT? ?  
(Month) (Day) (Year)  
 8. AGE: Years ? 72. Months ? Days ?  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

9. Birthplace KANSAS.  
(City, town, or county) (State or foreign country)  
 10. Usual occupation NIL.

11. Industry or business \_\_\_\_\_  
 12. Name WILLIAM C. ?  
 13. Birthplace UNKNOWN. 9  
(City, town, or county) (State or foreign country)  
 14. Maiden name UNKNOWN.  
 15. Birthplace UNKNOWN. 9  
(City, town, or county) (State or foreign country)

16. (a) Informant CITY INFIRMARY RECORDS.  
 (b) Address 5800 ARSENAL ST.  
 17. (a) BURIAL (b) Date thereof 10/17/45.  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Valhalla Cemetery.

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 \_\_\_\_\_

18. (a) Signature of funeral director C.R. Lupton & Sons.  
 (b) Address #7233 Delmar Bly'd.  
 19. (a) OCT 16 1945  
(Date received local registrar) J. F. Bredenk  
(Registrar's signature)

23. Signature Edward J. Staller (M. D. or other) M.D.  
 Address 5800 Arsenal St. Date signed 10/15/45.

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

17  
9

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

*Clarence H. Murray*

Licensed Embalmer No.....

*4011*

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