

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

21183

FILED JUN 28 1948

State File No. _____

Registration District No. 518

Primary Registration District No. 1003

Registrar's No. 5608

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:
St. Louis City Hospital - Max C. Starkloff Memorial
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 weeks
 (Specify whether years, months or days)
 In this community 30 years

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County foo
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2719 St. Vincent
Memorial 23 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME IVA MUMA
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month June day 17th
 year 1948 hour 3 minute 55 P. M.
 21. I hereby certify that I attended the deceased from 5/28/48
 _____, 19____, to June 17th, 1948
 that I last saw her alive on June 17th, 1948
 and that death occurred on the date and hour stated above.

4. Sex F / race W
 5. Color or _____
 6. (a) Single, widowed, married, divorced M
 6. (b) Name of husband or wife Earl
 6. (c) Age of husband or wife if alive 54 years
 7. Birth date of deceased July 6, 1896
 (Month) (Day) (Year)

Immediate cause of death Spargioblastoma left cerebral hemisphere
 Duration _____
 Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Spargioblastoma
 Of operations: _____
 Of autopsy: Spargioblastoma left cerebral hemisphere

8. AGE: Years Months Days If less than one day
51 11 11 hr. _____ min. _____
 9. Birthplace: St. James, Missouri
 (City, town, or county) (State or foreign country)
 10. Usual occupation House-wife

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.
 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? _____

11. Industry or business At Home
 12. Name William Collins
 13. Birthplace Missouri
 (City, town, or county) (State or foreign country)
 14. Maiden name Janie Bekham
 15. Birthplace Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant Earl Muma
 (b) Address 2719 St. Vincent
 17. (a) Burial (b) Date thereof 6/20/48
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Elmo, Illinois
 18. (a) Signature of funeral director A.W. McLaughlin
 (b) Address 2301 Lafayette Avenue
 19. (a) JUN 22 1948 J.F. Bredeck
 (Data received local registrar) (Registrar's signature)

23. Signature Carlisle A. Dyer M.D.
1515 Lafayette (e) Means of injury _____
 Address _____ Date signed 6/18/48

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

8095

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.....

Licensed Embalmer No. *3830*

P. O. Address *2301 Lafayette*

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.