

FILED FEB 2 1949

STANDARD CERTIFICATE OF DEATH

State File No. 2770
763
Registrar's No.

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY JO	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis MO	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Infirmary		d. STREET ADDRESS (If rural, give location) 4332 1/2 ST. Ferdinand	
3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) c. (Last) Hedgepath			4. DATE OF DEATH (Month) (Day) (Year) Jan. 23, 1949
5. SEX F	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH MAY 18 1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 73 if UNDER 1 YEAR: Months Days if UNDER 1 MIN. Hours Min.
11a. FATHER'S NAME PETER Chamberlain		11b. MOTHER'S MAIDEN NAME Unknown	11. BIRTHPLACE (State or foreign country) Unknown MO
13a. FATHER'S NAME		14. NAME OF HUSBAND OR WIFE Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Irene Weaver 4332 1/2 ST. Ferdinand
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH years ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis 2 1/2 DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Syphilitic aortitis, valvulitis years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 450	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Min.)		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 July 7, 1948, to Jan 23, 1949, that I last saw the deceased alive on Jan 23, 1949, and that death occurred at 4:15 AM., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Clarus L. Krag, M.D. - A		23b. ADDRESS 5600 Arsenal St St Louis MO	
23c. DATE SIGNED Jan 24 1949			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan 28 1949	
24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem		24d. LOCATION (City, town, or county) (State) St. Louis MO	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JAN 26 1949 J. B. Casater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. C. Green 4214 Delmar	

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 _____

Licensed Embalmer No. 4580

P. O. Address 4214 Delmar

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.