No. 300
10-48

FILED MAR 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5905

State File No. 1749

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis Mo.
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DePaul Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: 1904
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 5109 Ashland Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): Marlouise
b. (Middle):
c. (Last): Ahern

4. DATE OF DEATH (Month) (Day) (Year): Feb 23 1949

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Aug. 10, 1878
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Wisconsin
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: Felix Derouin
13b. MOTHER'S MAIDEN NAME: Olive Lablanac
14. NAME OF HUSBAND OR WIFE: John B. Ahern

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S SIGNATURE OR NAME: Frank B. Ahern — ADDRESS: 3676 Manola

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Diabetes Mellitus

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): 61
DUE TO (c): Flex

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? YES ☐ NO ☑

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-10-, 1948, *to* 2-23, 1949, *that I last saw the deceased alive on* 2-14-, 1949, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M. V. White MD
23b. ADDRESS: 803 N. Kingshighway
23c. DATE SIGNED: 2-23-49

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Feb 26, 1949
24c. NAME OF CEMETERY OR CREMATORY: National Cem. Jefferson
24d. LOCATION (City, town, or county) (State): Jefferson Barracks Mo.

DATE REC'D BY LOCAL REG.: FEB 24 1949
REGISTRAR'S SIGNATURE: J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE: Street-Carroll — ADDRESS: 4600 Nat'l Bridge Ave

(Licensed Embalmer's Statement on Reverse Side)

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.

Signed Ben Hoffman

Signed.....
Student Embalmer

Licensed Embalmer No. 4366

P. O. Address St Louis MO

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

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