

FILED MAR 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 6674
1530

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

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Normandy			
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital				d. STREET ADDRESS (If rural, give location) 7312 Huntington Dr			
3. NAME OF DECEASED (Type or Print) a. (First) Ida			b. (Middle) G.		c. (Last) Scrivner		4. DATE OF DEATH (Month) (Day) (Year) February 17 1949
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH July 13 1884		9. AGE (In years last birthday) 64	10. MONTHS 7	11. DAYS 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Benton Illa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Pearson			13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Late Wilford Scrivner		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Bernice Dillinger 7312 Huntington Dr			
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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 11 days					
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Anterior ischemic, generalized DUE TO (c) Hypertension					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. O2					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION —				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) Home		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Home m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR leo			
22. I hereby certify that I attended the deceased from 2/5/49, 19, to 2/16/49, 19, that I last saw the deceased alive on 2/16/49, 19, and that death occurred at 8:35 p.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Walter J. Dyer, M.D.				23b. ADDRESS 14 Hampton Valley Plaza		23c. DATE SIGNED 2/17/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Feb 19 1949		24c. NAME OF CEMETERY OR CREMATORY Zions Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Co MO	
DATE REC'D BY LOCAL REG. FEB 17 1949		REGISTRAR'S SIGNATURE J. B. Lasater			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Calvin F Feutz 4828 Nat bridge blvd		

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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 John A. Mlesian
Licensed Embalmer No. 4186
P. O. Address St. Louis, Mo

Signed _____
Student Embalmer

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.