

FILED MAR 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10250

State File No. 2280

318

1003

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 Missouri b. COUNTY MARI			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) township)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION Josephine Hospital				d. STREET ADDRESS (If rural, give location) 4422 Bessie			
3. NAME OF DECEASED (Type or Print) a. (First) Ruth		b. (Middle) C.		c. (Last) Kawell		4. DATE OF DEATH (Month) (Day) (Year) March 10, 1949	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH February 7, 1907	
9. AGE (In years last birthday) 42		10. UNDER 1 YEAR Months 1		11. UNDER 1 YEAR Days 3		12. UNDER 1 YEAR Hours 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator		10b. KIND OF BUSINESS OR INDUSTRY Bell Telephone		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME August Kawell		13b. MOTHER'S MAIDEN NAME Ida Raschke		14. NAME OF HUSBAND OR WIFE None			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Hollingsworth, 6718 Edison Ave.			
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.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Intestinal Obstruction Strangulated R. Inguinal Hernia Gangrene of Bowel DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Toxic Cordike Failure				INTERVAL BETWEEN ONSET AND DEATH 1 1/2 Day 1 Day 1 Day 2 Day	
19a. DATE OF OPERATION 2/8/49		19c. MAJOR FINDINGS OF OPERATION Strangulated Intestinal Obstruction; Gangrene of Bowel				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21f. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from 3/7 1949, to 3/10 1949, that I last saw the deceased alive on 3/10 1949, and that death occurred at 7:30 p.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) George J. McHawley				23b. ADDRESS 3903 Olive		23c. DATE SIGNED 3/11/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/14/49		24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri	
DATE REC'D BY LOCAL REG. MAR 12 1949		REGISTRAR'S SIGNATURE J. B. Sasser		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PROVOST UND. CO., 3710 N. Grand Blvd.			

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 Albert Mayfield

Licensed Embalmer No. 3077

P. O. Address _____

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.