

FILED APR 8 1949

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10314**
Registrar's No. **2799**

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	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Dieckman Bldg.		d. STREET ADDRESS (If rural, give location) 13a North Sarah St.	

3. NAME OF DECEASED (Type or Print) Cecilia LeVerd			4. DATE OF DEATH (Month) (Day) (Year) Mar. 25, 1949		
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S.	
8. DATE OF BIRTH Aug. 9th., 1880		9. AGE (In years last birthday) 68		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) 7 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mo.	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Eredest LeVerd		13b. MOTHER'S MAIDEN NAME Sophie Aubuchon	
14. NAME OF HUSBAND OR WIFE		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.	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Frances Mickel		18. ADDRESS 13a N/Sarah St.			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		DUPLICATE OF (b)			
DUPLICATE OF (c)		DUPLICATE OF (d)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUPLICATE OF (e)			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input 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)		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **5:15 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE <i>Edw. J. Doyle</i>		23b. ADDRESS 1300 Clomp		23c. DATE SIGNED 3-26-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Mar. 30, 1949		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		24e. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur J. Donnelly</i>			

DATE REC'D BY LOCAL REG. MAR 28 1949		REGISTRAR'S SIGNATURE <i>J. B. Sasate</i>		ADDRESS 3840 Lindell Blvd.	
--	--	--	--	--------------------------------------	--

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

19

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.....

W Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 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.