

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10401**
3121

FILED APR 15 1949

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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 Mo b. COUNTY MOU				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 50 yrs.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		17		
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John Hospital				d. STREET ADDRESS (If rural, give location) 1423 Tamm Ave.				
3. NAME OF DECEASED (Type or Print) Anna M Merriman			a. (First)		b. (Middle)		c. (Last)	
4. DATE OF DEATH 4/2/49		(Month)		(Day)		(Year)		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH May 12th. 1862		
9. AGE (In years last birthday) 86		10. UNDER 1 YEAR Months 10 Days _____		11. UNDER 24 HRS. Hours _____ Min. _____		12. CITIZEN OF WHAT COUNTRY? _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Mo		12. CITIZEN OF WHAT COUNTRY? _____		
13a. FATHER'S NAME Patrick Merriman			13b. MOTHER'S MAIDEN NAME Anna Gilmore			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. Nil		17. INFORMANT'S SIGNATURE OR NAME Harold Gilmore ADDRESS 4333 Lafayette Av				
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) Cerebral hemorrhage ANTECEDENT CAUSES Hypertension 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. 83 3.31X				INTERVAL BETWEEN ONSET AND DEATH 2 weeks 5 yrs		
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) _____		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 _____ m., from the causes and on the date stated above.								
23a. SIGNATURE E.H. Bowden M.D. (Degree or title)				23b. ADDRESS 634 N. Grand		23c. DATE SIGNED 4-5-49		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4/6/49		24c. NAME OF CEMETERY OR CREMATORY Calvary Cent		24d. LOCATION (City, town, or county) (State) St. Louis Mo		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE APR 6 1949 J. B. Basster		25. FUNERAL DIRECTOR'S SIGNATURE Harrigan & Sheehan Und Co		ADDRESS 4415 Washington 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 Me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Elton R. Remelius

Licensed Embalmer No. 4283

P. O. Address St. Louis, Mo.

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.