

No. 300  
10. 48

FILED APR 1 1949

# STANDARD CERTIFICATE OF DEATH

10766  
State File No. 2523

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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)			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis				c. LENGTH OF STAY (In this place)			
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital				c. CITY (If outside corporate limits, write RURAL and give township) Lindbergh Dr. Affton, Missouri.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
a. (First) Mary		b. (Middle) V.		c. (Last) Van Ronzelen		Date of Death March 19 1949	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH September 11, 1947	
9. AGE (In years last birthday) 1		IF UNDER 1 YEAR Months 6		IF UNDER 1 YEAR Days 8		IF UNDER 1 YEAR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) St. Louis Co., Mo.		12. CITIZEN OF WHAT COUNTRY? U S A	
13a. FATHER'S NAME William Van Ronzelen		13b. MOTHER'S MAIDEN NAME Doris Venn		14. NAME OF HUSBAND OR WIFE W			
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 Wm. Van Ronzelen Affton 23, Missouri			
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) <i>Mongolian</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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. <i>Congenital Heart Disease</i>				INTERVAL BETWEEN ONSET AND DEATH	
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 <i>March 6, 1949</i> to <i>March 19, 1949</i> ; that I last saw the deceased alive on _____, 19____, and that death occurred at <i>12:30 P.M.</i> from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <i>Edward H. Meier, M.D.</i>				23b. ADDRESS <i>1115 Centre Bldg</i>		23c. DATE SIGNED <i>9-19-49</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE March 21, 49		24c. NAME OF CEMETERY OR CREMATORY Old St. Johns Cemetery		24d. LOCATION (City, town, or county) (State) Mehlville, Mo. St. Louis Co., Mo.	
DATE REC'D BY LOCAL REG. MAR 21 1949		REGISTRAR'S SIGNATURE <i>J. B. Cassiter</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. Hoffmeister U. & L. Co. 7814 S. Broadway			

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

Mr. Leo ...  
Dr. Marc  
Born 928 ...  
No ...

**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 \_\_\_\_\_  
Student Embalmer  
Licensed Embalmer No. 2679  
P. O. Address 7814 S. Broadway

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.