

FILED APR 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11026

State File No.

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 401

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|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>St Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St Louis</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Carsonville</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis</u> | |
| c. LENGTH OF STAY (in this place) <u>17</u> 9 | | d. STREET ADDRESS (If rural, give location) <u>4432 Olive</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Penns Nursing Home</u> | | | |

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|--|------------|-------------|------------------------|--|
| 3. NAME OF DECEASED (Type or Print) <u>Elizabeth</u> | a. (First) | b. (Middle) | c. (Last) <u>Jirsa</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>2-17-1949</u> |
|--|------------|-------------|------------------------|--|

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|----------------------|-------------------------------|--|------------------------------------|---|------------------------|------------------------|----------------------|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>12-23-1891</u> | 9. AGE (In years last birthday) <u>57</u> | IF UNDER 1 YEAR Months | IF UNDER 12 HRS. Hours | IF UNDER 1 MIN. Min. |
|----------------------|-------------------------------|--|------------------------------------|---|------------------------|------------------------|----------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>St. Joseph's</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Garment Worker</u> | 11. BIRTHPLACE (State or foreign country) <u>Triumph Mo</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
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| 13a. FATHER'S NAME <u>John Jirsa</u> | 13b. MOTHER'S MAIDEN NAME <u>Elizabeth</u> | 14. NAME OF HUSBAND OR WIFE <u>unknown John Jirsa</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>()</u> | 16. SOCIAL SECURITY NO. <u>()</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>John Bummer</u> | ADDRESS <u>House Springs Mo</u> |
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| 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 | | INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Infection</u> | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Polycythemia vera</u> <u>294X</u> DUE TO (c) <u>Rt hemiplegia</u> | | |

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|------------------------|----------------------------------|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|----------------------------------|---|

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|--|--|---|
| 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) |
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| | | |
|--|--|---------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 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 Jan 15, 1947, to Feb 17, 1949, that I last saw the deceased alive on Feb 15, 1949, and that death occurred at 6: A. m., from the causes and on the date stated above.

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|---|-------------------------------------|---------------------------------|
| 23a. SIGNATURE (Degree or title) <u>Jewes Littmann MD</u> | 23b. ADDRESS <u>8231 Clayton Rd</u> | 23c. DATE SIGNED <u>2/17/49</u> |
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|---|--------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 24b. DATE <u>2-19-49</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>St Martins</u> | 24d. LOCATION (City, town, or county), (State) <u>High Ridge Mo</u> |
|---|--------------------------|--|---|

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|---|---|---|---------------------------------|
| DATE REC'D BY LOCAL REG. <u>2-20-49</u> | REGISTRAR'S SIGNATURE <u>Theresa Lunn</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>JH Bummer</u> | ADDRESS <u>House Springs Mo</u> |
|---|---|---|---------------------------------|

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

96
8

reverse

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.....

Howard R Rowland

Signed.....
Student Embalmer

Licensed Embalmer No. *3114*

P. O. Address *St Louis 10 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.