S. No. 300
v. 10.48

FILED MAY 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14021

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3671

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (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 (If not in hospital or institution, give street address or location): ST. ANTHONYS Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS
d. STREET ADDRESS (If rural, give location): 2629 ALLEN AV.

3. NAME OF DECEASED (Type or Print)
a. (First): ELIZABETH
b. (Middle):
c. (Last): MULVEHILL

4. DATE OF DEATH (Month) (Day) (Year): APRIL 22 - 1949

5. SEX: FEMALE
6. COLOR OR RACE: W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): W
8. DATE OF BIRTH: JUNE 22 - 1883
9. AGE (In years last birthday): 65
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): G
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: JAMES WARD.
13b. MOTHER'S MAIDEN NAME: unknown
14. NAME OF HUSBAND OR WIFE: William Mulvehill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME: Veronica Mulvehill
ADDRESS: 2629 Allen 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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ca Carcinoma of liver — INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hx
DUE TO (c) Hx

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Spondilithesis Lumbar — several yrs.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify): no
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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/26, 1949, *to* 4/22, 1949, *that I last saw the deceased alive on* 4/21, 1949, *and that death occurred at* 10 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE: [illegible] MD (Degree or title)
23b. ADDRESS: 3804 Wilmington Ave
23c. DATE SIGNED: 4/23/49

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: APRIL 25-49
24c. NAME OF CEMETERY OR CREMATORY: Resurrection Cem
24d. LOCATION (City, town, or county) (State): St Louis Cty Mo.

DATE REC'D BY LOCAL REG.: APR 25 1949
REGISTRAR'S SIGNATURE: J. B. Lacaster
25. FUNERAL DIRECTOR'S SIGNATURE: E. J. Schmur
ADDRESS: 3125 Lafayette Av

(Licensed Embalmer's Statement on Reverse Side)

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.

Signed Jos B Vollmer

Signed .....
Student Embalmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette Ave.

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.