

FILED MAY 28 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18139

State File No. \_\_\_\_\_

96  
0  
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORDS

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>6076</u>		Registrar's No. <u>907</u>	
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 OR TOWN <u>Wellston</u> <u>3</u> township)		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Wellston</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>enroute to County Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>6536 Hobart Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>Elizabeth</u> a. (First) <u>?</u> b. (Middle) <u>Mahood</u> c. (Last)			4. DATE OF DEATH <u>April 13 1949</u> (Month) (Day) (Year)				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>Married</u> (Specify)		8. DATE OF BIRTH <u>Nov. 27 1895</u>	
9. AGE (In years last birthday) <u>53</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 6 WKS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Martin Gaiser</u>		13b. MOTHER'S MAIDEN NAME <u>Christiane Walsh</u>		14. NAME OF HUSBAND OR WIFE <u>Wm. Mahood</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Wm. Mahood, 6536 Hobart Ave</u> ADDRESS			
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) <u>multiple comminuted fractures of both legs, crushing chest injuries &amp; shock-struck by truck</u> ANTECEDENT CAUSES <u>both legs, crushing chest injuries</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>&amp; shock-struck by truck</u> DUE TO (c) <u>2830 x 21 1700 21</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>18 24</u> <u>4 25</u>	
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) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Wellston, St. Louis, Mo. 96</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>4 13 49 A</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Struck by truck while crossing rd.</u>			
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 <u>11:45 A.</u> <u>noon</u> the causes and on the date stated above.							
23a. SIGNATURE <u>Ermald J. Uellman</u> (Degree or title) <u>Coroner</u>				23b. ADDRESS <u>Clayton, Mo.</u>		23c. DATE SIGNED <u>3/14/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>April 16 1949</u>		24c. NAME OF CEMETERY OR <u>Laurel Hill</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>	
DATE REC'D BY LOCAL REG. <u>4-28-49</u>		REGISTRAR'S SIGNATURE <u>Thurmond Lunn</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Jos. W. Clark, 1125 Hodiamont Ave</u> ADDRESS			

**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 \_\_\_\_\_

*Alfred J. Boedeker*

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. 2663

P. O. Address 1125 Hodiama

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.