

FILED JUL 9 1949

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BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY 5800 Arsenal St. b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo. c. LENGTH OF STAY (in this place) 7y, 7m. d. FULL NAME OF HOSPITAL OR INSTITUTION City Infirmary				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis d. STREET ADDRESS (If rural, give location) 5800 Arsenal St.			
3. NAME OF DECEASED (Type or Print) a. (First) Cora b. (Middle) May c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) June 6 1949		5. SEX Female		
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH August ? 1883		9. AGE (In years last birthday) 65-10-0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Nil		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME ? Hull		13b. MOTHER'S MAIDEN NAME ? Hull		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)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME 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, atherosclerosis, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis 1946 .Plus ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Senile Organic Brain Disease- Many Years. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
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)		920	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4722			
22. I hereby certify that I attended the deceased from _____, 19____, to June 6, _____, 1949, that I last saw the deceased alive on June 6, _____, 1949, and that death occurred at 3:30 pm., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Palmer Eugene Rowland M.D.				23b. ADDRESS		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE JUN 30 1949		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE J. B. Casater		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Rowland Memorial Service 4104 Manchester Ave.					

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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....  
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

**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.