

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21486

State File No. 5880

FILED JUL 15 1949

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis 9/2	
b. CITY OR TOWN St. Louis 0		c. CITY OR TOWN Claude Ia 11	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) N.W. 301 N. Sappington Road 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital			

3. NAME OF DECEASED (Type or Print) Cora Myers			4. DATE OF DEATH 7-5-1949		
a. (First)		b. (Middle)		c. (Last)	

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2	8. DATE OF BIRTH 9-5-1878	9. AGE (In years last birthday) 70	10. MONTHS 0	11. DAYS 0	12. HOURS 0	13. MIN. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri 0	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Michael Klein	13b. MOTHER'S MAIDEN NAME Caroline Swartz	14. NAME OF HUSBAND OR WIFE *****
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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.	17. INFORMANT'S SIGNATURE OR NAME William C. Myers 301 N. Sappington Rd	18. ADDRESS
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Failure		INTERVAL BETWEEN ONSET AND DEATH 5 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chron Myocarditis & coronary occlusion & infarct		
	DUE TO (c) Smoker & Hypertension		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arthritis			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Stone	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) none	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none	21c. (CITY, TOWN, OR TOWNSHIP) St. Louis (COUNTY) Miss (STATE) Mo
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) none	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H&H X
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22. I hereby certify that I attended the deceased from 2/18/47, 19__, to 7/5/49, 19__, that I last saw the deceased alive on ____, 19__, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE Walter H. Hoefler M.D. (Degree or title)	23b. ADDRESS 3108 S. Grand	23c. DATE SIGNED 7/5/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-7-1949	24c. NAME OF CEMETERY OR CREMATORY St. Trinity Lutheran Cem	24d. LOCATION (City, town, or county) (State) Lemay Ferry and Green Pk Mo
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DATE REC'D BY LOCAL REG. JUL 6 1949	REGISTRAR'S SIGNATURE J. B. Foster	25. FUNERAL DIRECTOR'S SIGNATURE Fiezenlen Bros 6409 Gravois Ave	ADDRESS
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Dr. Walter Hoefler, 3108 S. Grand
PR 5172 1/2 30 2 3
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 J. Allen Davis Jr.

Signed _____
Student Embalmer

Licensed Embalmer No. 4053

P. O. Address Theriot MD

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.