

FILED JUL 15 1949

FILED JUL 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21678

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5840

| | | | | | |
|--|------------------------|---|--|---|--------------------------|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo. ✓ | | c. LENGTH OF STAY (in this place) | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 17 | |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Louis City Hospital #2. | | d. STREET ADDRESS (If rural, give location) 23- 2843 Russell 18 | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) MARGARET b. (Middle) SHORT c. (Last) | | | 4. DATE OF DEATH (Month) (Day) (Year) 7/3/49 | | |
| 5. SEX Fe | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH Aug. 2, 1870 | 9. AGE (In years last birthday) 78 | IF UNDER 1 YEAR Months 9 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Bessville, Mo. 0 | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13a. FATHER'S NAME Eli Sitze | | 13b. MOTHER'S MAIDEN NAME Sisie Dellinger | |
| 14. NAME OF HUSBAND OR WIFE John Short | | 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. none | |
| 17. INFORMANT'S SIGNATURE OR NAME Mary Goodson | | ADDRESS 2843 Russell | | | |

| | | | | | | |
|--|--|------------------------------|--|--|----------------------------------|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized arteriosclerosis | | DUE TO (b) Diabetes Mellitus | | | 15 yrs. | |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | DUE TO (c) | | | 3 yrs. | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | |

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|--|--|--|--|---|--|--|
| 19a. DATE OF OPERATION 6-16-49 | | 19b. MAJOR FINDINGS OF OPERATION Gangrene of leg due to arteriosclerosis | | | 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) 97. | | |
| 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? H.S.P.O. | | |

22. I hereby certify that I attended the deceased from 5/26/49, 19__, to 7/3/49, 19__, that I last saw the deceased alive on 7/3/49, 19__, and that death occurred at 10.00 a.m., from the causes and on the date stated above.

| | | | | | |
|---|--|---|--|--|--|
| 23a. SIGNATURE (Degree or title) Richard M. Peters M.D. | | 23b. ADDRESS 1515 Lafayette Ave., | | 23c. DATE SIGNED 7/5/49 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE July 6 - 49 | | 24c. NAME OF CEMETERY OR CREMATORY Bollinger Co. Mo. | |
| 24d. LOCATION (City, town, or county) (State) Bollinger Co. Mo. | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A.W. McLaughlin 2301 Lafayette | | | |
| DATE REC'D BY LOCAL REG. JUL 5 1949 | | REGISTRAR'S SIGNATURE J. B. Lasater | | | |

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.

Student
Student Embalmer

Signed

C. W. Cooper

Licensed Embalmer No. *5830*

P. O. Address *2301 Lafayette*

Note: The above, **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.