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FILED JUL 30 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 25425  
6411

BIRTH NO. #99057 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	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		7-4948 N. UNION	

3. NAME OF DECEASED (Type or Print)	a. (First) EMMA	b. (Middle)	c. (Last) MONNETT	4. DATE OF DEATH (Month) (Day) (Year) July 22nd, 1949
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JULY 3 1873	9. AGE (In years last birthday) 76	10. UNDER 1 YEAR Months Days Hours Min. - 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) ST. LOUIS Mo!	12. CITIZEN OF WHAT COUNTRY? U.S.A.		

13a. FATHER'S NAME FRED ACKERMANN	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE JOSEPH A. MONNETT
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS JOSEPH A. MONNETT 4948 N. UNION
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral vascular accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>19 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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) 8300
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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? 324X
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22. I hereby certify that I attended the deceased from 7/3/49 19, to 7/22/49, 19, that I last saw the deceased alive on 7/22/49, 19, and that death occurred at 11:25am, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Paul M. Caldwell M.D.	23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 7/22/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE JULY 25 1949	24c. NAME OF CEMETERY OR CREMATORY ST. TRINITY LUTHERAN	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO.
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JUL 23 1949 J. B. Bosator	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kulis 2906 Gerwin
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

None

**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

*Samuel C. Hill*

Licensed Embalmer No. ....

*4347*

P. O. Address

*2906 Pearl*

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.