

FILED SEP 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28357**
7441

BIRTH NO. _____		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003	Registrar's No. _____
1. PLACE OF DEATH a. COUNTY 1088 Palm.		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY No.		
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis Mo.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis Mo.		
c. LENGTH OF STAY (in this place) _____		d. STREET ADDRESS (If rural, give location) 1922 Palm.		
d. FULL NAME OF HOSPITAL OR INSTITUTION 1922 Palm St.				
3. NAME OF DECEASED a. (First) Amanda J. Monroe		b. (Middle) _____		c. (Last) _____
4. DATE OF DEATH 8-25-49				
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH May 5 1878	9. AGE (In years last birthday) 71
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) unknown	12. CITIZEN OF WHAT COUNTRY? _____
13a. FATHER'S NAME Henry Koeneke		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Thornton Frank Monroe
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Thornton Frank Monroe
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocarditis ANTECEDENT CAUSES Endocarditis Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) cause unknown II. OTHER SIGNIFICANT CONDITIONS C-R-V disease Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH years years
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) 9200
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 1200
22. I hereby certify that I attended the deceased from Jan , 1947, to Aug , 1949, that I last saw the deceased alive on Aug 22, 1949 , and that death occurred at 7 P.M. , from the causes and on the date stated above.				
23a. SIGNATURE Harrison C. Moirley M.D.		23b. ADDRESS 3625 Fair One		23c. DATE SIGNED 8/26/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug 29 1949		24c. NAME OF CEMETERY OR CREMATORY 4th Str Meth Cem
24d. LOCATION (City, town, or county) (State) St. Charles Mo.		25. FUNERAL DIRECTOR'S SIGNATURE HENRY LEIDNER UNDERTAKING CO.		
DATE REC'D BY LOCAL REG. AUG 26 1949		REGISTRAR'S SIGNATURE J. B. Lavater		ADDRESS 2223 ST. LOUIS AVE.

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

OK
1917

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 John P. Buchholz

Licensed Embalmer No. 1274

P. O. Address 2223 St. Louis Ave

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.