

FILED SEP 12 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **28686**  
**7513**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b>				b. COUNTY <b>MOO</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Saint Louis, Missouri</b>			c. LENGTH OF STAY (In this place) <b>10 Weeks</b>			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Saint Louis,</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Missouri Baptist Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>3521 Arkansas Avenue,</b>					
3. NAME OF DECEASED (Type or Print) <b>Marie</b>			a. (First)		b. (Middle) <b>Wills</b>		c. (Last)		
4. DATE OF DEATH <b>August 27th, 1949</b>		(Month) (Day) (Year)		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Switchboard Operator</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Sheraton Hotel</b>			8. DATE OF BIRTH <b>Nov. 9th, 1908</b>		9. AGE (In years last birthday) <b>40</b>	
11. BIRTHPLACE (State or foreign country) <b>Saint Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Anthony Sanson</b>		13b. MOTHER'S MAIDEN NAME <b>Catherine Wagner</b>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Frances deLinere,</b> ADDRESS <b>2531 N. Grand Blvd.</b>					
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, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4/17/49</b>	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertensive cardiac vascular disease.</b>				1939	
				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 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) <b>MO</b>					
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? <b>Auto</b>					
22. I hereby certify that I attended the deceased from <b>July 14</b> , 1949, to <b>Aug 27</b> , 1949, that I last saw the deceased alive on <b>Aug 27</b> , 1949, and that death occurred at <b>4:45 A.M.</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>W. D. Brown, M.D.</b> (Degree or title)				23b. ADDRESS <b>390 S. Olsen</b>				23c. DATE SIGNED <b>8/29/49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>9/30/49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Saint Louis County, Missouri.</b>			
DATE REC'D BY LOCAL REG. <b>AUG 30 1949</b>		REGISTRAR'S SIGNATURE <b>J B Sarate</b>				25. FUNERAL DIRECTOR'S SIGNATURE <b>Calvin F. Feutz,</b> ADDRESS <b>4828 Natural Bridge Blvd.</b>			

(Licensed Embalmer's Statement on Reverse Side)

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.....  
Student Embalmer

Signed *John A. Mlenar*  
Licensed Embalmer No. *4186*

P. O. Address *St. Louis, Mo*

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.