

FILED OCT 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32001

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. **1003** Registrar's No. **8290**

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

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 OR TOWN St. Louis)		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (in this place) Life		d. STREET ADDRESS (If rural, give location) 3943 Page Blvd.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hosp.			

3. NAME OF DECEASED (Type or Print) a. (First) Bessie b. (Middle) c. (Last) Maul			4. DATE OF DEATH (Month) (Day) (Year) 9/22/49		
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	
8. DATE OF BIRTH 4/30/96		9. AGE (In years last birthday) 53		IF UNDER 1 YEAR: Months _____ Days _____	
IF UNDER 2 HRS: Hours _____ Min. _____		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) Troy, Missouri			12. CITIZEN OF WHAT COUNTRY? U.S.A.		

13a. FATHER'S NAME Will Owens		13b. MOTHER'S MAIDEN NAME Clara Ross		14. NAME OF HUSBAND OR WIFE Frank Maul	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 487-26-0897		17. INFORMANT'S SIGNATURE OR NAME Jas. Price, 3943 Page Blvd.	
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19. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Apoplexy DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" 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) ST. LOUIS			
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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? 334X			
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **6:35 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE Joseph P. DeGard (Degree or title)		23b. ADDRESS 1300 Clark Avenue		23c. DATE SIGNED 9/27/49	
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24a. BURIAL, CREMATION REMOVAL (Specify) Burial		24b. DATE 9/27/49		24c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
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DATE REC'D BY LOCAL REG. SEP 27 1949		REGISTRAR'S SIGNATURE J. B. Lasater		25. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Gates, 4107 Finney Avenue			
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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 R. Cunningham

Licensed Embalmer No. 4476

P. O. Address 4107 Finney Avenue

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.