

FILED DEC 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38636

State File No. _____

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 10313

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 10313	
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 town) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 6 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital				d. STREET ADDRESS (If rural, give location) 3715a Garfield Ave.			
3. NAME OF DECEASED (Type or Print) a. (First) Alice		b. (Middle) XX		c. (Last) MAE DAWE		4. DATE OF DEATH (Month) (Day) (Year) Nov. 28, 1949	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Feb. 2, 1875	
9. AGE (In years last birthday) 74		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME Cudahy		13b. MOTHER'S MAIDEN NAME _____		14. NAME OF HUSBAND OR WIFE Michael Hawe			
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 ADDRESS Clarence Dawe 4231 John Ave.			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary or Cerebral embolus ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) acute myocardial infarction DUE TO (c) Coronary arteriosclerosis Diabetes Mellitus II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND 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) _____		9.7 11/28/49	
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 _____			
22. I hereby certify that I attended the deceased from 11/22, 1949, to 11/28, 1949, that I last saw the deceased alive on 11/28, 1949, and that death occurred at 11:45 a.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Robert Polachnick M.D.				23b. ADDRESS 508 N. Grand		23c. DATE SIGNED 11/29/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12/1/49		24c. NAME OF CEMETERY OR CREMATORY Calvary Cem.		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. NOV 30 1949		REGISTRAR'S SIGNATURE J. B. Lusater		25. FUNERAL DIRECTOR'S SIGNATURE W. A. Stock		ADDRESS 2117 E. Grand Ave.	

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

Bob Colasnick

No 9695-

No 8017

508 N. Grand
6374 San Anita

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.

Signed _____

Frank A. Moore

Signed _____

Student Embalmer

Licensed Embalmer No. _____

3041

P. O. Address _____

2117 E. Grand

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.