

FILED DEC 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42575
State File No. _____
Registrar's No. 10560

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		b. COUNTY	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		d. STREET ADDRESS (If rural, give location) 8418 Minnesota	

3. NAME OF DECEASED (Type or Print)	a. (First) MARY	b. (Middle)	c. (Last) HENRY	4. DATE OF DEATH (Month) (Day) (Year) December 7th, 1949
-------------------------------------	-----------------	-------------	-----------------	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Nov. 24, 1873	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
---------------	------------------------	---	--------------------------------	------------------------------------	------------------------	-----------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY?
--	-----------------------------------	--	------------------------------

13a. FATHER'S NAME Patrick Henry	13b. MOTHER'S MAIDEN NAME Jane Shields	14. NAME OF HUSBAND OR WIFE
----------------------------------	--	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lloyd Burneson 8418 Minnesota
--	--	---

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hemorrhagic Cystitis</u>		
	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 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) 125
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? 6057

22. I hereby certify that I attended the deceased from 11/28/49, 19__ to 12/7/49, 19__, that I last saw the deceased alive on 12/7/49, 19__, and that death occurred at 0:40 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Claron Hendin (M.D.)</u>	(Degree or Title)	23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 12/8/49
--	-------------------	-----------------------------------	--------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-10-49	24c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cem.	24d. LOCATION (City, town, or county) (State) Bemay 23, Mo.
--	--------------------	---	---

DATE REC'D BY LOCAL REG. DEC 8 1949	REGISTRAR'S SIGNATURE <u>J. B. Lasater</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Southern Funeral Home, 6322 S. Grand Blvd.,
-------------------------------------	--	--

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

8

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.

Student
Student Embalmer

Signed *David Jan Fossan*

Licensed Embalmer No. *4249*

P. O. Address *6522 So. Ho*

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.