

FILED JAN 21 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2599

State File No. 91

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) 17 TOWN NORMANDY	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) Villa St. Louise	
d. FULL NAME OF HOSPITAL OR INSTITUTION DR. PAUL HOSPITAL 2111 KING HWY			
3. NAME OF DECEASED a. (First) Sister CHARLE		b. (Middle) LILLA AGNES	
c. (Last) HOCH		4. DATE OF DEATH (Month) (Day) (Year) JAN 3 1950	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH MAR 24 1870
9. AGE (In years last birthday) 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sister of Charity	11. BIRTHPLACE (State or foreign country) Penn
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME HOWARD HOCH	
13b. MOTHER'S MAIDEN NAME Priscilla McGinley		14. NAME OF HUSBAND OR WIFE	
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 Sister Leonie Villa St. Louise NORMANDY			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia INTERVAL BETWEEN ONSET AND DEATH 30 days ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Glomerulonephritis (chronic) or congestive heart failure DUE TO (b) _____ 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) 131			
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? 592X			
22. I hereby certify that I attended the deceased from 11/21 1949 , to 1/3 1950 , that I last saw the deceased alive on 11/20 1950 , and that death occurred at 2:30 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE [Signature]		23b. ADDRESS Humboldt Rd. St. Louis Mo.	
23c. DATE SIGNED 1/3/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE JAN 5 1950	
24c. NAME OF CEMETERY OR CREMATORY MARILAC		24d. LOCATION (City, town, or county) (State) NORMANDY St. Louis, Mo. MO.	
DATE REC'D BY LOCAL REG. JAN 5 1950		REGISTRAR'S SIGNATURE [Signature]	
25. FUNERAL DIRECTOR'S SIGNATURE Cullen Kelly		ADDRESS 4286 Lindell	

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed James G. Lammers

Licensed Embalmer No. 4142

P. O. Address St. Louis

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.