

FILED FEB 17 1950

STANDARD CERTIFICATE OF DEATH

6307

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1183**

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 township) OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 5091 Page Blvd.,	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5091 Page Blvd.,		6	

3. NAME OF DECEASED (Type or Print) a. (First) Julia b. (Middle) A c. (Last) Heller		4. DATE OF DEATH (Month) (Day) (Year) Feb 5, 1950	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed ✓	8. DATE OF BIRTH Feb 28, 1884
9. AGE (In years) (last birthday) 65		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Patrick Foley		13b. MOTHER'S MAIDEN NAME Dehlla Newell		14. NAME OF HUSBAND OR WIFE Walter Heller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No Nil		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Dorothy Bradley - 5091 Page Blvd.,	

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) Carcinoma Ascending Colon		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: 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 6/15/49	19b. MAJOR FINDINGS OF OPERATION Same as above		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) 1531	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 2-6-50 7:30 p.m.	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 **June 1, 1949**, to **2-6, 1950**, that I last saw the deceased alive on **2-6, 1950**, and that death occurred at **10:22 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE L. Hayden M.D. (Degree or title)		23b. ADDRESS 5899 Bluem		23c. DATE SIGNED 2/6/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-8-50	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	

DATE REC'D BY LOCAL REG. FEB 6 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Harrigan-Sheahan-5434 No Kingshighwa
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(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 *Clara R. Padwell*

Licensed Embalmer No. *4077*

P. O. Address _____

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.