

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7100

FILED MAR 4 1950

State File No. _____

Registrar's No. 315

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 4465

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>2249</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rock Hill</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	
c. LENGTH OF STAY (in this place) <u>5 yrs.</u>		d. STREET ADDRESS (If rural, give location) <u>3823 Indiana Ave.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Rock Hill Rest Home</u> 9803 Manchester			

3. NAME OF DECEASED a. (First) <u>Sophie</u> b. (Middle) <u>Heumann</u> c. (Last) <u>Heumann</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>February 5, 1950</u>		
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5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>Sept. 2, 1870</u>		9. AGE (in years last birthday) <u>79</u>		10. IF UNDER 1 YEAR <u>5</u> Months <u>3</u> Days		11. IF UNDER 2 HRS. <u>0</u> Hours <u>0</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				11. BIRTHPLACE (State or foreign country) <u>St. Louis, MO.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			

13a. FATHER'S NAME <u>Christian Heumann</u>			13b. MOTHER'S MAIDEN NAME <u>Magdalena Kempf</u>			14. NAME OF HUSBAND OR WIFE <u>None</u>		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>William O. Heumann 4051 Blow St.</u>			
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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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>		DUE TO (b) <u>Arterio sclerosis</u>						<u>24 hrs.</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c)						<u>10 yrs</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								<u>331x</u>	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>331x</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (STATE)	
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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?	
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22. I hereby certify that I attended the deceased from 1-27, 1950, to Feb. 5, 1950, that I last saw the deceased alive on Feb. 4, 1950, and that death occurred at 6:15 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Stan. McRae, D.O.</u>		23b. ADDRESS <u>25023 Washington Ave.</u>		23c. DATE SIGNED <u>Feb. 5, 1950</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2/7/50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Lakewood Park Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>	
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DATE REC'D BY LOCAL REGISTRY <u>FEB 6 1950</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Wombe</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John H. Gebken 2630 Gravois Ave.</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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201
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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.....

.....
working under my personal supervision.

..... Student Embalmer No.....

Signed.....

Robert T. Giffen

Signed.....
..... Student Embalmer

Licensed Embalmer No. 4144.....

P. O. Address 2630 Gravois Ave......

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.