

FILED MAY 1 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1003  
State File No. 14884  
Registrar's No. 3607

318

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
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 _____			
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>2229</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		d. STREET ADDRESS (If rural, give location) <u>1435 Morrison Lane</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1435 Morrison Lane</u>				d. STREET ADDRESS (If rural, give location) <u>1435 Morrison Lane</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>E. Lechett</u>		b. (Middle) <u>Agnes</u>		c. (Last) <u>Palitte</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 17-1950</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>April 20 1865</u>	9. AGE (In years last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>27</u>	IF UNDER 18 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Old Mines Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Thomas Dean</u>		13b. MOTHER'S MAIDEN NAME <u>Julia Boyer</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Peter Bequette</u> ADDRESS <u>1435 Morrison</u>			
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) <u>Cerebral Hemorrhage</u>  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>7 years</u> <u>10 years</u>	
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) <u>331X</u>			
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 <u>May 10, 1948</u> , to <u>April 17, 1950</u> , that I last saw the deceased alive on <u>April 17, 1950</u> , and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Willard J. Rush - D.O.</u>				23b. ADDRESS <u>1829 S. 18th St St Louis Mo</u>		23c. DATE SIGNED <u>4/18/50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4-20-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Josephs Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Washington Co. Mo.</u>		
DATE REC'D BY LOCAL REG. OFF. <u>APR 2-1950</u>		REGISTRAR'S SIGNATURE <u>J. B. Foster</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Mr. Luther Sparks Peter Mo.</u>			

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

4500

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 Murphy L. Sparks

Licensed Embalmer No. 17236

P. O. Address Flat River, Mo.

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.