

FILED JUN 15 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18174

State File No. 4769

318

1003

BIRTH NO.		REG. DIST. NO.	PRIMARY REG. DIST. NO.	Registrar's No.
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		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Richmond Heights 4485		
d. FULL NAME OF (If not in hospital or institution, give street address or location) c. HOSPITAL OR INSTITUTION Lutheran Hospital 4 Days		No. STREET ADDRESS 7460 Warner Ave		
3. NAME OF DECEASED (Type or Print) a. (First) Margaret b. (Middle) Mary c. (Last) Flack			4. DATE OF DEATH (Month) (Day) (Year) 5-28-1950	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 7-10-1887	9. AGE (In years last birthday) 62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Thomas O'Rourke		13b. MOTHER'S MAIDEN NAME Emma Baumann	14. NAME OF HUSBAND OR WIFE William Flack	
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 William Flack 7460 Warner Ave	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarct ANTECEDENT CAUSES DUE TO (b) Coronary Occlusion DUE TO (c) Sclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes, Hypertension		INTERVAL BETWEEN ONSET AND DEATH 2hr. 40min 2hr 40min 5 hrs Unknown
19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION None		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) St. Louis Missouri		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) 5/27/50 11:00 a.m.	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? None H2O1		
22. I hereby certify that I attended the deceased from June 1949 to 5-28-1950 , that I last saw the deceased alive on 5/27/50 19 50 , and that death occurred at 8:30 A. m. , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) Walter H. Hoffmann MD		23b. ADDRESS 3108 S. Grand	23c. DATE SIGNED 5/31/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-1-1950	24c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery	24d. LOCATION (City, town, or county) (State) 1800 Lemay Ferry Road Mo	
DATE REC'D BY LOCAL REG. MAY 31 1950	REGISTRAR'S SIGNATURE J. B. Basster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Jiegenheim Bros 6409 Gravois	

(Licensed Embalmer's Statement on Reverse Side)

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

02-2133

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

Robert M. Murray

Licensed Embalmer No. _____

3749

P. O. Address _____

St. Louis 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.