

FILED JUN 17 1950

STANDARD CERTIFICATE OF DEATH

State File No. 21587

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1984

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

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 ST. LOUIS 2219	
c. LENGTH OF STAY (In this place) 30 yrs.		d. STREET ADDRESS (If rural, give location) 3017 Showae 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION STATE HOSPITAL			

3. NAME OF DECEASED (Type or Print) a. (First) CEOLA		b. (Middle) HANNS		c. (Last) HANNS		4. DATE OF DEATH (Month) (Day) (Year) June 1 1950	
5. SEX F. ♀	6. COLOR OR RACE N.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE ♀		8. DATE OF BIRTH 7-28-09		9. AGE (In years last birthday) 40	
10a. USUAL OCCUPATION (Only kind of work done during most of working life, even if retired) maid		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) STONEWALL Miss!		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME ROMIE HANNS		13b. MOTHER'S MAIDEN NAME BARKS DALE		14. NAME OF HUSBAND OR WIFE none	
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 Basie Clifton	
				18. Bot ADDRESS 2401 Robert	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ventricular Fibrillation		ANTECEDENT CAUSES			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		Auricular flutter c̄			
DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		Cardiac decompensation		2 weeks	
DUE TO (c)		Cause undetermined			
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 checked="" type="checkbox"/> NO <input 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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4343	

22. I hereby certify that I attended the deceased from April 1, 1950, to June 1, 1950, that I last saw the deceased alive on June 1, 1950, and that death occurred at 9:30 a. m., from the causes and on the date stated above.

23a. SIGNATURE Arthur K. Trishel M.D.		23b. ADDRESS 5400 Arsenal St.		23c. DATE SIGNED 6/2/50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 6-9-50		24c. NAME OF CEMETERY OR CREMATORY Brewwood Slm.		24d. LOCATION (City, town, or county) (State) 6500 St. Louis, Mo.	
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DATE REC'D BY LOCAL REG. JUN 6 1950		REGISTRAR'S SIGNATURE J. B. ...		25. FUNERAL DIRECTOR'S SIGNATURE G. L. Allen		ADDRESS 4368 Washington	
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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

F. G. Green

Signed
Student Embalmer

Licensed Embalmer No. 2963

P. O. Address 4214 Delmar

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.