

FILED AUG 29 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28303

#113794

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7081

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri.
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Louis City Hospital #1.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MO.
b. COUNTY
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2199
d. STREET ADDRESS (If rural, give location) 448 WHITTIER STREET

3. NAME OF DECEASED (Type or Print)
a. (First) MAUDE b. (Middle) HOLMES c. (Last)
4. DATE OF DEATH (Month) (Day) (Year) August 19th, 1950

5. SEX FEMALE
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH JUNE 21 1875
9. AGE (In years last birthday) 75
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) GA
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Z. T. WRIGHT
13b. MOTHER'S MAIDEN NAME EMMA MUIP
14. NAME OF HUSBAND OR WIFE FLOYD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME ADDRESS FLOYD HOLMES 448 WHITTIER

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.
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subarachnoid hemorrhage, left cerebral hemisphere.
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
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES NO

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)
21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK
21f. HOW DID INJURY OCCUR 330X

22. I hereby certify that I attended the deceased from 8/4/50 to 8/19/50; 19, that I last saw the deceased alive on 8/19/50, 19, and that death occurred at 5:35am m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John W. Koshly MD
23b. ADDRESS 1515 Lafayette Ave.,
23c. DATE SIGNED 8/19/50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE June 22 50
24c. NAME OF CEMETERY OR CREMATORY Memorial Park
24d. LOCATION (City, town, or county) (State) St. Louis County MO

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE AUG 21 1950 J. B. Sauter
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Cullen Killy 4386 LINDOEN

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.

Signed.....
Student Embalmer

Signed *Ronald A. York*
Student Embalmer No.....

Licensed Embalmer No. *3917*

P. O. Address *St. Louis*

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.