

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31697

State File No.

FILED OCT 5 1950

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No. 8161

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 Franklin	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN New Haven 0354	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) C. c. (Last) Helm		4. DATE OF DEATH (Month) (Day) (Year) Sept. 25, 1950	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH July 10, 1867
9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours Min.
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) New Haven, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.			
13a. FATHER'S NAME Ben Maupin		13b. MOTHER'S MAIDEN NAME Calista Gibson	14. NAME OF HUSBAND OR WIFE Fred Helm
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Miss Maud Helm, New Haven, Mo.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chr. Cardiac valvular disease		INTERVAL BETWEEN ONSET AND DEATH 15 yrs	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		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		Chr. Intestinal hepatics	
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 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H 21.4	
22. I hereby certify that I attended the deceased from April 1st, 1950 , to 9-25, 1950 , that I last saw the deceased alive on 9-25, 1950 , and that death occurred at 8:30 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE J. B. ALTHEIDE (Degree or title) MD		23b. ADDRESS 607 N grand	23c. DATE SIGNED 9/26
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9/26/1950	24c. NAME OF CEMETERY OR CREMATORY New Haven	24d. LOCATION (City, town, or county) (State) Missouri
DATE REC'D BY LOCAL REG. SEP 27 1950		REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe ADDRESS 4700 Washington

DEPT. 1 NON

MAR 23 1955

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 me

.....
working under my personal supervision.

Student Embalmer No.

Signed.....



Signed.....
Student Embalmer

Licensed Embalmer No. 4699

P. O. Address St. Charles

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.