

FILED OCT 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34807

State File No.

318

REG. DIST. NO. PRIMARY REG. DIST. NO. 1003 Registrar's No. 8355

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

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. 8355	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE _____ b. COUNTY _____ Mo.			
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <u>St. Louis, Mo.</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo.</u>		2069	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Baptist Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>5647 Roosevelt Pl.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mery</u> b. (Middle) <u>Frame.</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 2, 1950</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>May 25, 1925.</u>	9. AGE (In years last birthday) <u>25</u>	IF UNDER 1 YEAR Months _____	IF UNDER 24 HRS. Days _____	IF UNDER 4 HRS. Hours _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Armature Winder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baldor Electric</u>		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>John Callahan</u>		13b. MOTHER'S MAIDEN NAME <u>Lydia Moses</u>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Lydia Moses.</u>		ADDRESS <u>5647 Roosevelt</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Peritonitis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>acute gangrenous appendix</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>✓</u>				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Peritonitis & gangrenous appendix</u>				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)			
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? <u>5501</u>			
22. I hereby certify that I attended the deceased from <u>Sept 29, 1950</u> , to <u>Oct 2, 1950</u> , that I last saw the deceased alive on <u>Oct 2, 1950</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>C. H. Kulker M.D.</u>				23b. ADDRESS <u>3121 N Grand</u>		23c. DATE SIGNED <u>10-3-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct. 5, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY: <u>Calvary Cemetery.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>OCT 4 1950</u>		REGISTRAR'S SIGNATURE <u>J. B. Sasser</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Quinn</u>		ADDRESS <u>1389 Union Bly</u>	

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

Ronald J. Schickel

Licensed Embalmer No. *3917*

P. O. Address.....

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.