

FILED NOV 24 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38464

9553

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	c. LENGTH OF STAY (in this place) <u>3 Years</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	<u>2169</u>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION. <u>Little Sisters of Poor</u>		d. STREET ADDRESS (If rural, give location) <u>3400 So. Grand Blvd</u>	<u>0</u>
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>Stanley</u> c. (Last) <u>Esson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 9, 1950</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 30, 1863</u>
9. AGE (In years last birthday) <u>87</u>		# UNDER 1 YEAR Months _____ Days _____	# UNDER 2 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Accountant</u>	11. BIRTHPLACE (State or foreign country) <u>Canada</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>		13a. FATHER'S NAME <u>William Esson</u>	
13b. MOTHER'S MAIDEN NAME <u>Julia Harris</u>		14. NAME OF HUSBAND OR WIFE <u>Stella Esson</u>	
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 <u>Mrs. J.S. Brennan</u>		ADDRESS <u>6127 Westminster</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>Coronary Insufficiency</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Arterio Sclerosis</u> II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>	
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 <u>H2O1</u>		22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>11.00A.M.</u> , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <u>Arthur J. Donnelly M.D.</u>		23b. ADDRESS <u>607 W. Grand</u>	
23c. DATE SIGNED <u>11/9/50</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>Nov. 11, 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>NOV 10 1950</u>	
REGISTRAR'S SIGNATURE <u>J. B. Lassiter</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Donnelly</u>	
ADDRESS <u>3840 Lindell Blvd</u>			

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.

Student Embalmer No.

Signed *Thomas R. Fenwick*

Signed.....
Student Embalmer

Licensed Embalmer No. *3793*

P. O. Address *3840 Lindell*

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.