No. 300
10-48

FILED DEC 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39166

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10117

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis Mo
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): 3725 French Av

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis 2019
d. STREET ADDRESS (If rural, give location): 3725 French Av 0

3. NAME OF DECEASED (Type or Print)
a. (First): Frances
b. (Middle):
c. (Last): Westbrook

4. DATE OF DEATH (Month) (Day) (Year): Nov 27 1950

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 7 1884
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: 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): Czechoslovakia 6
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Ujknown
14. NAME OF HUSBAND OR WIFE: Joseph Westbrook

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: Joseph Westbrook — ADDRESS: 3725 French Av

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cardiovascular Hypertension
DUE TO (c): Symptomatic

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND 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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 4201

22. *I hereby certify that I attended the deceased from* Jan, 1945, *to* Nov. 27, 1950, *that I last saw the deceased alive on* Nov 26, 1950, *and that death occurred at* 8:35 A.M. *from the causes and on the date stated above.*

23a. SIGNATURE: C. Kienzle 0 (Degree or title): MD
23b. ADDRESS: 2800 H Chippewa
23c. DATE SIGNED: 11/28/50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 0
24b. DATE: 11/30/50
24c. NAME OF CEMETERY OR CREMATORY: Sunset Burial Park
24d. LOCATION (City, town, or county) (State): St Louis Mo.

DATE REC'D BY LOCAL REG.: NOV 28 1950
REGISTRAR'S SIGNATURE: J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE: Meydell Funeral Home — ADDRESS: 1926 Allen Av

(Licensed Embalmer's Statement on Reverse Side)

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 Dale A. Straumann

Signed.....
Student Embalmer

Licensed Embalmer No. 4533

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.