

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 6 1951

318

1003

State File No. 2756
906 Registrar's No.

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|---|--|---|---|---|--|--|--|--|
| BIRTH NO. | | REG. DIST. NO. | | PRIMARY REG. DIST. NO. | | Registrar's No. | | |
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY | | | | |
| b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis | | c. LENGTH OF STAY (in this place) | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | 2069 | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 5516 Wells Avenue | | | | d. STREET ADDRESS 5516 Wells Avenue | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Rose McCormick b. (Middle) c. (Last) | | | 4. DATE OF DEATH (Month) (Day) (Year) Jan 27 1951 | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2 | | 8. DATE OF BIRTH Oct 30 1870 | | |
| 9. AGE (In years last birthday) 80 | | 10. MONTHS 2 | | 11. BIRTHPLACE (State or foreign country) St. Louis, Missouri | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13a. FATHER'S NAME Phillip Winter | | | 13b. MOTHER'S MAIDEN NAME Kate Smith | | | 14. NAME OF HUSBAND OR WIFE Deceased | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Elizabeth Snyder 5516 Wells | | | | |
| 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) <i>Atherosclerotic Valvular Heart Disease</i> 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. <i>Arthritis Deformans 8 yrs.</i> | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>11 months</i> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | 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) m. | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <i>H214</i> | | | | |
| 22. I hereby certify that I attended the deceased from <i>29 Dec, 1950</i> , to <i>27 Jan, 1951</i> , that I last saw the deceased alive on <i>22 Jan, 1951</i> and that death occurred at <i>10:45 am.</i> , from the causes and on the date stated above. | | | | | | | | |
| 23a. SIGNATURE <i>William M. Hall M.D.</i> (Degree or title) | | | 23b. ADDRESS <i>5516 Wells Avenue</i> | | | 23c. DATE SIGNED <i>29 Jan 51</i> | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial (1)</i> | | 24b. DATE <i>Jan 30 1951</i> | | 24c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i> | | 24d. LOCATION (City, town, or county) (State) <i>St. Louis, Missouri</i> | | |
| DATE REC'D BY LOCAL REG. <i>JAN 29 1951</i> | | REGISTRAR'S SIGNATURE <i>J. B. Foster</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>4746 Bromschwig and Son W Florissant</i> | | | | |

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

Dr Eugene Hall
25a S Florissant Rd.
Ferguson

[Handwritten mark]

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 *Robert M. Murray*
Student Embalmer No.....
Licensed Embalmer No. *3749*

P. O. Address *St. Louis, Mo.*

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.