

S. No. 30
v. 10.48

FILED JAN 26 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3394

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 32

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____	
b. CITY OR TOWN Manchester	c. LENGTH OF STAY (in this place) _____	c. CITY OR TOWN St. Louis	2039
d. FULL NAME OF HOSPITAL OR INSTITUTION Pine Crest Nurseing Home		d. STREET ADDRESS (If rural, give location) 6011 Fyler	

3. NAME OF DECEASED a. (First) ALPHONSA b. (Middle) A. c. (Last) MARKS			4. DATE OF DEATH (Month) 1 (Day) 5 (Year) 51		
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH June 3, 1861		9. AGE (In years last birthday) 89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Wellsville Mo.		12. CITIZEN OF WHAT COUNTRY? _____

13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Samuel Marks	
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. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. I.B. UNGAR 6011 Fyler		

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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis		
	DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS 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 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? _____		

22. I hereby certify that I attended the deceased from 6-15, 1946, to 1-5, 1951, that I last saw the deceased alive on 1-2, 1951, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) _____		23b. ADDRESS 5899 Delmar		23c. DATE SIGNED 1-6-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 1/7/51	24c. NAME OF CEMETERY OR CREMATORY Mt. Sinai	24d. LOCATION (City, town, or county) (State) St. Louis County Mo.		

DATE REC'D BY LOCAL REG. 1/6/51	REGISTRAR'S SIGNATURE Herbert R. Donke Md.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mayor 4356 Lindell Blvd	
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(Licensed Embalmer's Statement on Reverse Side)

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

4000
4

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

[Handwritten Signature]

Signed.....
Student Embalmer

Licensed Embalmer No. 4699

P. O. Address St. Charles, 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.