

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10121

State File No. 1999

FILED MAR 19 1951

318

1003

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 OR TOWN Saint Louis)	c. LENGTH OF OR TOWN 22 yrs	c. CITY (If outside corporate limits, write RURAL and give township) Saint Louis 2199 1)	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital			
1/9 STREET ADDRESS 4030 Lindell Boulevard		(If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) EMILY		b. (Middle)		c. (Last) GIEST		4. DATE OF DEATH (Month) (Day) (Year) Feb. 28 1951	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married		8. DATE OF BIRTH Sept. 23 1883		9. AGE (In years last birthday) 67 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursing		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Rimbach, Germany 4		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE	
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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 Herman Geist ADDRESS 2050a Ann	
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

Cerebral Apoplexy
Chronic hypertrophic myocarditis

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) 4222 (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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **4:35 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE <i>Patricia E. Taylor</i> (Degree or title)		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 3.1.51	
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24a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) Burial		24b. DATE Mar. 3 1951		24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery		24d. LOCATION (City, town, or county) (State) Saint Louis County Mo.	
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DATE REC'D BY LOCAL REG. MAR 1 1951		REGISTRAR'S SIGNATURE <i>S. B. Parster</i>		25. FUNERAL DIRECTOR'S SIGNATURE Truth Center Mortuary ADDRESS 4024 Lindell	
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Ronald O. Yahube

Licensed Embalmer No.

3917

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.