

FILED MAY 4 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

13742
3961

No. 300
10-48

318

1002

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 township) 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 2039

d. FULL NAME OF HOSPITAL OR INSTITUTION 7129 EMILIE AVE d. STREET ADDRESS (If rural, give location) 7129 EMILIE AVE

3. NAME OF DECEASED (Type or Print) a. (First) EVA b. (Middle) MARIE c. (Last) AXCELL 4. DATE OF DEATH (Month) (Day) (Year) APRIL 24, 1951

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED* (Specify) WIDOW 8. DATE OF BIRTH NOV. 13, 1864 9. AGE (In years last birthday) 86 IF UNDER 1 YEAR Months Days IF UNDER 1 HR. Hours Min.

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) ST. LOUIS, MO. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME FRANK ZAHN 13b. MOTHER'S MAIDEN NAME GERTRUDE LINK 14. NAME OF HUSBAND OR WIFE _____

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 SUSIE AXCELL-7129 EMILIE ADDRESS _____

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 15 hours
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. General arteriosclerosis years _____

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) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? 331X

22. I hereby certify that I attended the deceased from April 24, 1951, to April 24, 1951, that I last saw the deceased alive on April 24, 1951, and that death occurred at 3 P. m., from the causes and on the date stated above.

23a. SIGNATURE Vincent F. Townsend MD (Degree or title) 23b. ADDRESS 3101st Sutton Ave Maplewood 17th 23c. DATE SIGNED 4.26.51

24a. BURIAL, CREMATION, REMOVAL (Specify) NO BIAL 24b. DATE 4-27-51 24c. NAME OF CEMETERY OR CREMATORY SS. PETER & PAUL 24d. LOCATION (City, town, or county) (State) ST. LOUIS MO.

DATE REC'D BY LOCAL REG. APR 27 1951 REGISTRAR'S SIGNATURE J. B. Lasater 25. FUNERAL DIRECTOR'S SIGNATURE M. J. CROGHAN ADDRESS 7146 MANCHESTER

(Licensed Embalmer's Statement on Reverse Side)

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

1968

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

Student Embalmer No.....

Signed

Lita Subroadet

Licensed Embalmer No.

3691

P. O. Address

Richmond, Va.

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.