

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14030**
Registrar's No. **3369**

FILED APR 20 1951

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2149	
c. LENGTH OF STAY (in this place)		14 STREET ADDRESS (If rural, give location) 6367 Sutherland Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1			
3. NAME OF DECEASED (Type or Print) BLANCHE		a. (First)	b. (Middle)
		c. (Last) EMMONS	
4. DATE OF DEATH APR. 8 1951		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH Feb. 14 1890		9. AGE (In years last birthday) 61	
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?	
13a. FATHER'S NAME John O'Donnell		13b. MOTHER'S MAIDEN NAME Ellen Tierney	
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.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lucille Gass; 6367 Sutherland Ave.	
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) Cirrhosis liver 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. Hypertensive Cardiovascular Disease	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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? 3810			
22. I hereby certify that I attended the deceased from 3-19-51 , 19___, to 4-8-51 , 19___, that I last saw the deceased alive on 4-8-51 , 19___, and that death occurred at 10:15P m. , from the causes and on the date stated above.			
23a. SIGNATURE Albert Edward Stock MD (Degree or title)		23b. ADDRESS 1515 Lafayette Avenue	
23c. DATE SIGNED 4-9-51			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4/11/51	
24c. NAME OF CEMETERY OR CREMATORY Calvary		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
DATE REC'D BY LOCAL REG. APR 10 1951		REGISTRAR'S SIGNATURE J B Sasser	
25. FUNERAL DIRECTOR'S SIGNATURE Sullivan Funeral Dir.		ADDRESS 2849 N. Euclid	

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.

Student
Student Embalmer

Student Embalmer No. _____

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.