

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28812**

FILED SEP 13 1951

318

REG. DIST. NO. **1002** PRIMARY REG. DIST. NO. **2712** Registrar's No. **2712**

1. PLACE OF DEATH a. COUNTY 0		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) St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2209	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		d. STREET ADDRESS (If rural, give location) 2814 N. 22nd St. 0	
3. NAME OF DECEASED (Type or Print) a. (First) JENNIE		b. (Middle) Lea	
c. (Last) VAN ALSTYNE		4. DATE OF DEATH (Month) (Day) (Year) AUGUST 31 1951	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 5, 1905
9. AGE (In years last birthday) 46		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Nolie E. Hennington		13b. MOTHER'S MAIDEN NAME Lela Guynes	
14. NAME OF HUSBAND OR WIFE Leo		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Leo VanAlstyne, 2914 N. 22nd St.	
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) Pneumonia, lobar INTERVAL BETWEEN ONSET AND DEATH 3 days 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. (CNS Les) ??	
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? H90XB		22. I hereby certify that I attended the deceased from 8-26-51 , 19___, to 8-31-51 , 19___, that I last saw the deceased alive on 8-31-51 , 19___, and that death occurred at 12:15A m. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Chas. Sprunt M.D.		23b. ADDRESS 1515 Lafayette Avenue	
23c. DATE SIGNED 8-31-51		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 8-31-51		24c. NAME OF CEMETERY OR CREMATORY Srystal Springs	
24d. LOCATION (City, town, or county) (State) Crystal Springs, Miss.		25. FUNERAL DIRECTOR'S SIGNATURE Morrell Funeral Home, 4212 St. Louis	
25. ADDRESS 4212 St. Louis		26. (Licensed Embalmer's Statement on Reverse Side)	

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

X

1951 7 2 1957 SA

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 Embalmer No.

Signed Robert M Murray

Signed.....
Student Embalmer

Licensed Embalmer No. 2747

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.