

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35441

State File No. _____

FILED NOV 2 1951

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1002 Registrar's No. 9028

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 ST. LOUIS, MISSOURI)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis <u>2269</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1		d. STREET ADDRESS (If rural, give location) 2008 Mallinckrodt Street	

3. NAME OF DECEASED (Type or Print)	a. (First) LILLI	b. (Middle)	c. (Last) MURRI	4. DATE OF DEATH (Month) (Day) (Year) OCT. 11 1951
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 7, 1881	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 60 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) St. Louis, MO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Charles Smith	13b. MOTHER'S MAIDEN NAME Maggie Bailey	14. NAME OF HUSBAND OR WIFE John Murri
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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) NO	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME John Murri	ADDRESS 2008 Mallinckrodt Street
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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, asthma, 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) PSYCHOSIS & CEREBRAL ARTERIO-SCLEROSIS		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE 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"/>
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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? H22K

22. I hereby certify that I attended the deceased from 12-6-50, 19___, to 10-11-51, 19___, that I last saw the deceased alive on 10-11-51, 19___, and that death occurred at 5:40 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Edwin N. Schmidt, M.D.	23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 10-12-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-13-51	24c. NAME OF CEMETERY OR CREMATORY Galvany Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, MO.
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DATE REC'D BY LOCAL REG. OCT 15 1951	REGISTRAR'S SIGNATURE Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE SUEDMEYER & SON'S	ADDRESS 3934 N. 20 Street
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 *Eustace W. Dietrich*

Licensed Embalmer No. *4329*

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.