

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39311

FILED DEC 8- 1951

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1003

State File No. ....

9916

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)	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		b. COUNTY St. Louis	
c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) Pine Lawn 4151	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hosp.		d. STREET ADDRESS (If rural, give location) 4011 Cedarwood /	

3. NAME OF DECEASED (Type or Print)	a. (First) Margaret	b. (Middle)	c. (Last) Lawson	4. DATE OF DEATH (Month) (Day) (Year) Nov 6th 1951
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Nov. 11-1892	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoemaker	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Grand Island Neb. /	12. CITIZEN OF WHAT COUNTRY?
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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 Wm. Lawson	ADDRESS 5505 Hebert St.
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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, asthemia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Chronic myocardial</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Several years</i>
	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.		

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)
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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? <i>4222</i>
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22. I hereby certify that I attended the deceased from *Sept 28, 1951* to *Nov 6, 1951*, that I last saw the deceased alive on *Nov 6, 1951*, and that death occurred at *8:00 P.M.* from the causes and on the date stated above.

23a. SIGNATURE <i>W. Q. Brown</i>	(Degree or title)	23b. ADDRESS <i>W 3903 Olive</i>	23c. DATE SIGNED <i>11/8/51</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/10/51	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
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DATE REC'D BY LOCAL HEALTH DEPT. NOV 8 1951	REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D., K.P.</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Sullivan Funeral Dir.</i>	ADDRESS 2849 N. Euclid
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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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed Gustav W. Dieterle

Signed.....  
Student Embalmer

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.