

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6493

State File No.

1136

Registrar's No.

FILED FEB 27 1952

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No.		Registrar's No.			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY _____							
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis</u>			c. LENGTH OF STAY (In this place) <u>4-MON.</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>			2059				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Stone Nursing Home, 4373 W. Pine</u>				d. STREET ADDRESS (If rural, give location) <u>6000 Waterman Ave.</u>							
3. NAME OF DECEASED (Type or Print) a. (First) <u>Margaret</u>			b. (Middle) _____			c. (Last) <u>Ikemeier</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 4, 1952</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W.</u>		8. DATE OF BIRTH <u>Sept. 11, 1873</u>		9. AGE (In years last birthday) <u>78</u>	10. UNDER 1 YEAR Months <u>4</u> Days <u>23</u>	11. UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13a. FATHER'S NAME <u>Michael Casey</u>			13b. MOTHER'S MAIDEN NAME <u>Mary O'Neil</u>			14. NAME OF HUSBAND OR WIFE <u>Anthony Ikemeier</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. C. E. Mooney, 5929 Waterman Ave.</u>							
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) <u>Cerebral thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 mo</u>	
				ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cardiovascular disease</u>						2 yrs	
				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 <u>no</u>		19b. MAJOR FINDINGS OF OPERATION _____								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>		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) <u>no</u>		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. HOW DID INJURY OCCUR? <u>3.3.2 X</u>						
22. I hereby certify that I attended the deceased from <u>Aug 14</u> , 19 <u>48</u> , to <u>Feb 4</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>Jan 4</u> , 19 <u>52</u> , and that death occurred at <u>11 P. m.</u> , from the causes and on the date stated above.											
23a. SIGNATURE (Degree or title) <u>Dr. Frank J. Langan M.D.</u>				23b. ADDRESS <u>5803 Plymouth Ave St. Louis, Mo.</u>				23c. DATE SIGNED <u>Feb 5, 1952</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb. 7, 1952</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>			24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>					
DATE REC'D BY REG. <u>FEB 5 1952</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>			FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>			ADDRESS <u>340 Lindell Blvd.</u>			

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

APR 15 1959

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 me

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

Wm S. Latta

Licensed Embalmer No. 4699

P. O. Address St. Charles, 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.