

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **17878**
 Registrar's No. **4726**

FILED JUN 6 1952

BIRTH NO. _____ 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 MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS Mo	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2139	
d. FULL NAME OF HOSPITAL OR INSTITUTION STATE HOSPITAL		d. STREET ADDRESS (If rural, give location) 13 5400 ARSENAL	

3. NAME OF DECEASED (Type or Print) a. (First) MAYME b. (Middle) CRECELIOUS c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) MAY 21, 1952		
5. SEX female	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH FEB. 22 1893	9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months Days Hours Mts.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and State or Foreign Country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? U

13a. FATHER'S NAME AUGUST GOERGEN		13b. MOTHER'S MAIDEN NAME AMELIA MENGES		14. NAME OF HUSBAND OR WIFE Geo. CRECELIOUS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS. CYNTHIA KNORR 4418 MICHIGAN	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH 4/23/52
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		DUE TO (b) Arteriosclerosis			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 332X			

22. I hereby certify that I attended the deceased from **1-1-51**, 19**51**, to **5-21**, 19**52**; that I last saw the deceased alive on **5-21**, 19**52**, and that death occurred at **12:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Mary Jean Murphy, M.D.		23b. ADDRESS 5400 Arsenal Street		23c. DATE SIGNED 5/21/52	
24a. BURIAL (CREMATION, REMOVAL) (Specify)	24b. DATE MAY 23 1952	24c. NAME OF CEMETERY OR CREMATORY BETHANY CEM.	24d. LOCATION (City, town, or county) (State) ST. LOUIS Mo		
DATE REC'D BY LOCAL REG. MAY 22 1952	REGISTRAR'S SIGNATURE Charles Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutis 2906 Gravois	ADDRESS		

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 43479

P. O. Address 2906 Jarvis

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.