No. 300
10.48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30231

State File No. .....

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 590 Registrar's No. 2258

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

1. PLACE OF DEATH
a. COUNTY: St. Louis 4006
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): University City
c. LENGTH OF STAY (in this place): 2 wks.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6534 Julian Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gerald 0360
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Sarah
b. (Middle): Jane
c. (Last): Adams

4. DATE OF DEATH (Month) (Day) (Year): Aug. 29, 1952

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Aug. 23, 1875
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and State or Foreign Country): Enemic, Mo.
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: William Hicks
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: William

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: Ira Adams, Gerald, Mo.
ADDRESS:

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): Cardiovascular disease
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Senility
DUE TO (c): 4221
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: None

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: None

22. *I hereby certify that I attended the deceased from* 8/1, 1952, *to* 8/29, 1952, *that I last saw the deceased alive on* 8/28, 1952 *and that death occurred at* 1:20a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Bruce J. Reilly MD
23b. ADDRESS: St. Louis Mo. 730 Hodiamont
23c. DATE SIGNED: 8/29/52

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 8-29-52
24c. NAME OF CEMETERY OR CREMATORY:
24d. LOCATION (City, town, or county) (State): Owensville, Mo.

DATE REC'D BY LOCAL REG.: 8-29-52
REGISTRAR'S SIGNATURE: Herbert R. Domke MD
25. FUNERAL DIRECTOR'S SIGNATURE: Albert H. Hoppe, 4700 Washington Blvd
ADDRESS:

(Licensed Embalmer's Statement on Reverse Side)

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 John S. Kennedy

Licensed Embalmer No. 4194 J

P. O. Address.....

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.