

FILED DEC 2 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40387**
 BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10330**

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		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2149	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHN'S HOSPITAL 14		d. STREET ADDRESS (If rural, give location) 4946^a THOLOZAN	
3. NAME OF DECEASED (Type or Print) a. (First) EMMA b. (Middle) c. (Last) KILLIAN		4. DATE OF DEATH (Month) (Day) (Year) 11-9-52	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 8-28-1881
9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 2 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work denoting most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MO
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME NOT KNOWN	
13b. MOTHER'S MAIDEN NAME NOT KNOWN		14. NAME OF HUSBAND OR WIFE BEN F. KILLIAN	
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 Ben F Killian		ADDRESS 4946^a Tholozan	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic coronary thrombosis DUE TO (c) Hypertensive C.V. Disease	
INTERVAL BETWEEN ONSET AND DEATH 2 hrs		1 yr	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR 4201		22. I hereby certify that I attended the deceased from Feb 10 1948 , to 11-9-1952 , that I last saw the deceased alive on 10-4-1952 , and that death occurred at 3:15 P. m., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Kenneth M. Smith M.D.		23b. ADDRESS 5203 Chippewa	
23c. DATE SIGNED 11-10-52		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 11-12-52		24c. NAME OF CEMETERY OR CREMATORY St. Peter's Cem.	
24d. LOCATION (City, town, or county) (State) St. Louis Co. MO		25. FUNERAL DIRECTOR'S SIGNATURE A. Row Hills	
DATE REC'D BY LOCAL REG. NOV 10 1952		ADDRESS 2707 St. Grand	

(Licensed Embalmer's Statement on Reverse Side)

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 Ronald O Yahrke

Signed.....
Student Embalmer

Licensed Embalmer No. 3917

P. O. Address St Louis

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.