

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14695**
Registrar's No. **12081**

FILED JAN 26 1953

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 Mo 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 2169	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3425A M^eKEAN		d. STREET ADDRESS (If rural, give location) 16 3425A M^eKEAN	
3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) ELLEN c. (Last) ALTUS			4. DATE OF DEATH (Month) (Day) (Year) DEC-30-52
5. SEX FE	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH JULY-11-1881
9. AGE (In years last birthday) 71 YRS	# OUNCES 1 YEAR Months	# OUNCES 1 YEAR Days	# OUNCES 1 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper	10b. KIND OF BUSINESS OR INDUSTRY own	11. BIRTHPLACE (City and State or Foreign Country) ST. Louis Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME PETER HALLORAN		13b. MOTHER'S MAIDEN NAME BRIDGET M^e Connick	
14. NAME OF HUSBAND OR WIFE CHARLES ALTUS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Charles Altus	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) ART. sclerotic Heart Disease to failure 6 Mos. DUE TO (c) Generalized Arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma Breasts, Metastatic	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. INTERVAL BETWEEN ONSET AND DEATH 2 Days	
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 4200	
22. I hereby certify that I attended the deceased from 8 , 19 52 , to 12/29 , 19 52 , that I last saw the deceased alive on 12/29 , 19 52 , and that death occurred at 2:35A m., from the causes and on the date stated above.			
23a. SIGNATURE John B. Summers, M.D. (Degree or title)		23b. ADDRESS 2767^a Park	23c. DATE SIGNED 12/31/52
24a. BURIAL OR CREMATION REMOVAL (Specify)	24b. DATE JAN-2-53	24c. NAME OF CEMETERY OR CREMATION S.S.P. + Paul's Cem.	24d. LOCATION (City, town, or county) (State) St. Louis Mo
DATE REC'D BY LOCAL REG. DEC 31 1952	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. J. Schmur 3125 Lafayette	

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 B. Volmer

Licensed Embalmer No. *4014*

P. O. Address *3125 Lafayette*

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.