

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **4297**

No. 300
10-48

FEB 10 1953

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **391**

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

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lemay		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lemay	
c. LENGTH OF STAY (in this place) 5 yrs		4. DATE OF DEATH (Month) (Day) (Year) Jan. 31, 1953	
d. FULL NAME OF HOSPITAL OR INSTITUTION 918 Lemay Ferry Rd		d. STREET ADDRESS (If rural, give location) 918 Lemay Ferry Rd	
3. NAME OF DECEASED (Type or Print) a. (First) MARY		c. (Last) HALL	
b. (Middle)		4. DATE OF DEATH (Month) (Day) (Year) Jan. 31, 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Aug 15, 1864
9. AGE (In years last birthday) 88		IF UNDER 1 YEAR Months Days	
IF UNDER 1 YEAR Hours Mins.		11. BIRTHPLACE (City and State or Foreign Country) New York	
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) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Louis Layer		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Thomas Hall		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Thomas Hall Jr	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		ADDRESS 1929 Virginia	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ac. dilatation of heart		INTERVAL BETWEEN ONSET AND DEATH 1/2 hrs.	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) chronic cardio. vascular disease	
DUE TO (c)		DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS 443X		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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?	
22. I hereby certify that I attended the deceased from Nov. 1, 1949 , to Jan 31, 1953 , that I last saw the deceased alive on 1-21, 1953 , and that death occurred at 7:30P m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Ernie S. Creel M.D.		23b. ADDRESS 712 Lemay Ferry Rd	
23c. DATE SIGNED 2-2-53		24a. BURLIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE Feb 3, 53		24c. NAME OF CEMETERY OR CREMATORY Lakewood Park	
24d. LOCATION (City, town, or county) (State) St. Louis Cty Mo		25. FUNERAL DIRECTOR'S SIGNATURE E.J. Schnur	
DATE REC'D BY LOCAL REG. 2-2-53		ADDRESS 3125 Lafayette	

(Licensed Embalmer's Statement on Reverse Side)

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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. Palmer

Licensed Embalmer No. *21114*

P. O. Address *3195 Palmyra*

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.