

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7598**
Registrar's No. **1842**

BIRTH MAR 11 1953 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		c. CITY (If outside corporate limits, write RURAL and give township): OR TOWN St. Louis 2199	
d. FULL NAME OF HOSPITAL OR INSTITUTION Saint. Louis Maternity		d. STREET ADDRESS (If rural, give location). 19 4212 West Pine	
3. NAME OF DECEASED (Type or Print) a. (First) Hall b. (Middle) Hall c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) January 29 1953	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) --	8. DATE OF BIRTH January 28 1953
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis Missouri		12. CITIZEN OF WHAT COUNTRY? --	
13a. FATHER'S NAME --		13b. MOTHER'S MAIDEN NAME Virginia Mae R Hoffman	
14. NAME OF HUSBAND OR WIFE --		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) --	
16. SOCIAL SECURITY NO. --		17. INFORMANT'S SIGNATURE OR NAME Virginia Mae R Hall	
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) Subarachnoid Hemorrhage ANTECEDENT CAUSES DUE TO (b) Anoxia Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Prematurity	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" 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? 7625		22. I hereby certify that I attended the deceased from Jan 28 , 19 53 , to Jan 29 , 19 53 that I last saw the deceased alive on Jan 29 , 19 53 , and that death occurred at 11:55 p. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Miriam M. Pennoyer MD		23b. ADDRESS 630 S. Kingshighway	
23c. DATE SIGNED 2-2-53		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE 2-28-53		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Carl Smith MD Rowland	
DATE REC'D BY LOCAL REG. FEB 17 1953		ADDRESS 4104 Manchester	

1953 OCT 9 6 100

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. _____

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.