

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11971

State File No. 2182
Registrar's No. 2182

FILED MAR 18 1953

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

2

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, Mo.		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2139		d. STREET ADDRESS (If rural, give location) 13 5400 Arsenal St. 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital						
3. NAME OF DECEASED (Type or Print) a. (First) BIRDIE b. (Middle) MANNE c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Feb. 18, 1953.			
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 2	8. DATE OF BIRTH 10/7/94	9. AGE (In years last birthday) 58	10. UNDER 1 YEAR Days 4 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steno-music teacher		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Macon Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME - Austin		13b. MOTHER'S MAIDEN NAME not known		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 ADDRESS Hospital Record 5400 Arsenal St.			
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) Cerebral Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Syphilis- Central nervous system 6 yrs x DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH 2/17/53
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 026X				
22. I hereby certify that I attended the deceased from Jan. 1, 1950, to Feb. 18, 1953, that I last saw the deceased alive on Feb. 18, 1953, and that death occurred at 5:45 p. m., from the causes and on the date stated above.						
23a. SIGNATURE (Degree or title) Anna Ayman MD			23b. ADDRESS 5400 Arsenal St.		23c. DATE SIGNED 2/20/53	
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.			
DATE REC'D BY LOCAL REG. FEB 26 1953	REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL HOME'S SIGNATURE ADDRESS 4104 Manchester Ave.			

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.