

FILED MAR 31

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **12503**  
Registrar's No. **2751**

BIRTH NO.		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>2751</b>		
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Missouri</b>			c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Pine Lawn</b> <b>4161</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>6235 Creston</b>				
3. NAME OF DECEASED (Type or Print), <b>ELIZABETH</b>			a. (First)	b. (Middle)	c. (Last) <b>WHELAN</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>MARCH 11, 1953</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>		8. DATE OF BIRTH <b>Unknown</b>		
9. AGE (In years last birthday) <b>78</b>		IF UNDER 1 YEAR Months		IF UNDER 1 HOUR Hours		IF UNDER 15 MIN. Mins.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OAA</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>--Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>John ?</b>			13b. MOTHER'S MAIDEN NAME <b>Ann ?</b>			14. NAME OF HUSBAND OR WIFE <b>Unknown</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Mari Ackert 6235 Creston</b>				
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.								
<b>MEDICAL CERTIFICATION</b>								
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>								
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____								
II. OTHER SIGNIFICANT CONDITIONS: <b>1) CHRONIC BRAIN SYNDROME ASSOCIATED WITH CEREBRAL ARTERIOSCLEROSIS. 2) DIABETES MELLITUS 3) PERNICIOUS ANEMIA</b>								
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)		21f. HOW DID INJURY OCCUR <b>443X</b>		
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"/>						
22. I hereby certify that I attended the deceased from <b>3-21-50</b> , 19___, to <b>3-11-53</b> , 19___, that I last saw the deceased alive on <b>3-11-53</b> , 19___, and that death occurred at <b>8:40A</b> m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <b>Edwin N. Schmidt M.D.</b>				23b. ADDRESS <b>1515 Lafayette Avenue</b>		23c. DATE SIGNED <b>3-11-53</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>3-14-53</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Bethany Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>		
DATE REC'D BY LOCAL REG. <b>MAR 12 1953</b>		REGISTRAR'S SIGNATURE <b>Edwin N. Schmidt M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Stroot-Carroll</b>		ADDRESS <b>4600 Natural Bridge</b>		

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....

Student Embalmer

Signed

*Albert Mayfield*

Licensed Embalmer No. *3077*

P. O. Address *St Louis MO*

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.