

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12767

State File No.

FILED MAR 21 1953

BIRTH NO. REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 590 Registrar's No. 774

1001
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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		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Pine Lawn Mo.		c. LENGTH OF STAY (In this place) 4 mon.	d. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2169
d. FULL NAME OF HOSPITAL OR INSTITUTION Shamrock Nursing Home			d. STREET ADDRESS (If rural, give location) 3839 A. Dunnica		
3. NAME OF DECEASED (Type or Print) a. (First) Elizabeth b. (Middle) c. (Last) Martin			4. DATE OF DEATH (Month) (Day) (Year) Mch. 8 1953		
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH June 9 1882	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months 8 Days 29
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 (State or foreign country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Charles Schindler		13b. MOTHER'S MAIDEN NAME Unk nown		14. NAME OF HUSBAND OR WIFE Luther Martin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Edw. Keckler 3839 A. Dunnica		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 1 year
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of the Colon	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				153X
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 1) U.S. CV disease 2) Obesity 3) Colostomy 6 months				
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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			
22. I hereby certify that I attended the deceased from Nov 26 1952 to March 8 1953 , that I last saw the deceased alive on March 2 1953 , and that death occurred at 11-30A , from the causes and on the date stated above.					
23a. SIGNATURE Lewis Littmann M.D.			23b. ADDRESS 8231 Clayton Rd (17)		23c. DATE SIGNED 3/9/53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-11-53	24c. NAME OF CEMETERY OR CREMATORY St. Matthews	24d. LOCATION (City, town, or county) (State) St. Louis Mo.		
DATE REC'D BY LOCAL REG. 3-9-53	REGISTRAR'S SIGNATURE Herbert R. Damb...		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Schumacher Und. Co. 3013 Meramec		

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. 4746

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.