

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15707**
4316
Registrar's No. _____

No. 300
10-48

FILED MAY 14 1953

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

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 St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR St. Louis 2189	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		d. STREET ADDRESS (If rural, give location) 3317 Hickory 0	
3. NAME OF DECEASED (Type or Print) a. (First) A. D. b. (Middle) c. (Last) Furla		4. DATE OF DEATH (Month) (Day) (Year) April 24 1953	
5. SEX 3 Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 9- 1901
9. AGE (In years last birthday) 52		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) LA.
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Jerrie Franklin	
13b. MOTHER'S MAIDEN NAME Sarah Brooks		14. NAME OF HUSBAND OR WIFE Scott Furla	
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. 367-28-7753	
17. INFORMANT'S SIGNATURE OR NAME Scott Furla		ADDRESS 3317 Hickory	
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) Bronchopneumonia ANTECEDENT CAUSES DUE TO (b) Undetermined <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (c) Uremia II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>	
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 491X			
22. I hereby certify that I attended the deceased from 4-20 19 53 , to 4-24 , 1953 , that I last saw the deceased alive on 4-24 , 19 53 , and that death occurred at 7:30a m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Edna E. Brooks M. D.		23b. ADDRESS 2601 N Whittier St.	
23c. DATE SIGNED 4-25-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4-29-53	
24c. NAME OF CEMETERY OR CREMATORY Oakdale		24d. LOCATION (City, town, or county) (State) Lemay MO	
DATE REC'D BY LOCAL REG. APR 27 1953		REGISTRAR'S SIGNATURE J. C. Smith M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE J. J. Stahon		ADDRESS 3749 Chouteau	

(Licensed Embalmer's Statement on Reverse Side)

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

1070

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 _____

.....
working under my personal supervision.

Student Embalmer No. _____

Student
Student Embalmer

Signed _____



Licensed Embalmer No. _____

2698

P. O. Address _____

2719 Chouteau

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.