

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **15958****4431**

FILED MAY 14 1953

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
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 <b>St. Louis</b>		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		<b>2239</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>2347a Park Ave.</b>				d. STREET ADDRESS (If rural, give location) <b>23 2347a Park Ave.</b>			
3. NAME OF DECEASED (Type or Print) <b>MATHILDA</b>		a. (First)		b. (Middle)		c. (Last) <b>McCARTY</b>	
4. DATE OF DEATH <b>Apr. 28 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>May 3, 1879</b>		9. AGE (In years last birthday) <b>73</b>		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired School Board Member</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <b>Peter Sondag</b>		13b. MOTHER'S MAIDEN NAME <b>Pauline Kale</b>		14. NAME OF HUSBAND OR WIFE <b>Florence McCarty (Dec'd.)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <b>Harry McCarty 2347a Park Ave.</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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral embolism</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio scler. Cardio Vasc Dis</u> DUE TO (c) <u>Auricular Fibrillation</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>  <b>10 yrs</b>  <b>3 yrs</b>	
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) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>4200</b>			
22. I hereby certify that I attended the deceased from <u>Nov 10, 1952</u> , to <u>Apr. 28, 1953</u> , that I last saw the deceased alive on <u>27 April, 1953</u> , and that death occurred at <u>8:10 AM.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Norman W. Deery M.D.</b>				23b. ADDRESS <b>607 N. Grand</b>		23c. DATE SIGNED <b>4/30/53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>May 1, 1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>New St. Marcus Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>APR 30 1953</b> <b>J. Earl Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Kriegshauser</b>		ADDRESS <b>4228 S. Kingshighway Bl.</b>			

(Licensed Embalmer's Statement on Reverse Side)

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 Edwin A. M. Gerwitz

Licensed Embalmer No. 3024

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.