

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19781

State File No. ....

FILED JUN 1 - 1953

BIRTH NO. ....

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 4760

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois		b. COUNTY Madison	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 1 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Granite City 8120	
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital		d. STREET ADDRESS (If rural, give location) 2033 Madison Ave.,			
3. NAME OF DECEASED (Type or Print) JULIA		a. (First)		b. (Middle) PRICE	
c. (Last)		4. DATE OF DEATH		(Month) (Day) (Year) May 11, 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 4, 1879	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME William C. Merritt		13b. MOTHER'S MAIDEN NAME Martha J. Surse		14. NAME OF HUSBAND OR WIFE Henry P.	
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. unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Fannie Finneran 775 Goodfellow	
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 Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH 7 days 2 yrs 3 yrs
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 331X	
22. I hereby certify that I attended the deceased from 4/9 1953 to 5/11 1953, that I last saw the deceased alive on 5/11 1953, and that death occurred at 9:50 AM, from the causes and on the date stated above.		23a. SIGNATURE (Type or Print) J. K. Mostachnik		23b. ADDRESS 3903 Olive St	
23c. DATE SIGNED 5/11/53		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5-11-53	
24c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		24d. LOCATION (City, town, or county) Granite City, Illinois		(State)	
DATE REC'D BY LOCAL REG. MAY 11 1953		REGISTRAR'S SIGNATURE J. C. Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sedlack Granite City, Ill.	

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.....

.....  
working under my personal supervision.

Signed John T. Sedlack Student Embalmer No. ....

Signed.....  
Student Embalmer

Licensed Embalmer No. 3747

P. O. Address Madison, Ill

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.