

FILED JUL 31 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **26675**  
Registrar's No. **6093**

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 <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>6150 Oakland Ave.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Hilda</b> b. (Middle) <b>Elizabeth</b> c. (Last) <b>Mark</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>June 17, 1953.</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Nov. 27, 1902</b>	9. AGE (In years last birthday) <b>50</b>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Deaconess</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Hamilton, Ohio</b>	
			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		

13a. FATHER'S NAME <b>John Mark</b>		13b. MOTHER'S MAIDEN NAME <b>Emma Hoffman</b>		14. NAME OF HUSBAND OR WIFE <b>None</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. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Sister Olivia Drusch, 6150 Oakland 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) <b>AMYOTROPHIC LATERAL SCLEROSIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>YES.</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 Conditions contributing to the death but not related to the disease or condition causing death.			

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? <b>3561</b>	

22. I hereby certify that I attended the deceased from **6-13, 1953**, to **6-17, 1953**, that I last saw the deceased alive on **6-16, 1953**, and that death occurred at **6:15 Am.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Robert E. Spach</b> (Degree or title) <b>M.D.</b>		23b. ADDRESS <b>35 N. Central, Mo</b>		23c. DATE SIGNED <b>6-17-53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>6/19/53.</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b>	
		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>			

DATE REC'D BY LOCAL REG. <b>JUN 18 1953</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith, MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Calvin F. Feutz, 4828 Natural Bridge Blvd</b>	
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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 *John A. Mlinar*

Licensed Embalmer No. *4186*

P. O. Address *St. Louis Mo*

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.