

FILED AUG 20 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30512**
Registrar's No. **7394**

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 TOWN ST. LOUIS,		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, 2109 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4125 a WEST KOSSUTH AVE		d. STREET ADDRESS (If rural, give location) 10 4125 a WEST KOSSUTH AVE	

3. NAME OF DECEASED (Type or Print)	a. (First) MARY	b. (Middle) E.	c. (Last) WARD	4. DATE OF DEATH (Month) (Day) (Year) JULY 29, 1953
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH 2/5/1880	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS MISSOURI 0	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME THOMAS MORAN	13b. MOTHER'S MAIDEN NAME MARY LOFTUS	14. NAME OF HUSBAND OR WIFE
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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. # 194-07-5217	17. INFORMANT'S SIGNATURE OR NAME MARY WARD HEINTZ	ADDRESS 4125 a WEST KOSSUTH
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		DUE TO (b) Diabetes mellitus		3 days
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)		5 years
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"/>
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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) 260X
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

22. I hereby certify that I attended the deceased from January, 1952, to July 29, 1953, that I last saw the deceased alive on July 28, 1953, and that death occurred at 6:50 a.m., from the causes and on the date stated above.

23a. SIGNATURE Augustine Jones	(Degree or title) M.D.	23b. ADDRESS 634 N. Grand Whiskies	23c. DATE SIGNED 7-29-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 8/1/53	24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	24d. LOCATION (City, town, or county) (State) ST. LOUIS MISSOURI
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DATE REC'D BY LOCAL REG. JUL 30 1953	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE STROOT - CARROLL	ADDRESS 1600 NATURAL BRIDGE AVE
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(Licensed Embalmer's Statement on Reverse Side)

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

*of new
The Cheater Bldg*

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: *M. W. Ruter*

Licensed Embalmer No. *4865*

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.