

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33040

State File No. \_\_\_\_\_  
Registrar's No. **9229**

FILED OCT 15 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

<b>1. PLACE OF DEATH</b> a. COUNTY _____			<b>2. USUAL RESIDENCE</b> (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, Missouri</b>		c. LENGTH OF STAY (in this place) _____	c. CITY OR TOWN <b>St. Louis,</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital</b>			e. STREET ADDRESS (If rural, give location) <b>4322 No. Florrissant Ave.</b>		
<b>3. NAME OF DECEASED</b> (Type or Print) a. (First) <b>EASTER</b> b. (Middle) _____ c. (Last) <b>CONWAY</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>SEPTEMBER 22, 1953</b>		
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>Unknown</b>		<b>9. AGE</b> (In years last birthday) <b>59</b> If UNDER 1 YEAR: Months _____ Days _____ If UNDER 1 HRS.: Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during part of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>At Home</b>	<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>Ava Mo.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>
<b>13a. FATHER'S NAME</b> <b>Unknown</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Ray Conway</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If specify war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None.</b>		<b>17. INFORMANT'S SIGNATURE OR NAME</b> ADDRESS <b>Ray Conway 4322 No. Florrissant.</b>	
<b>18. CAUSE OF DEATH</b> 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.			<b>MEDICAL CERTIFICATION</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Arteriosclerotic Heart Disease</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
			<b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		
			<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.		
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>			<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____ m.		<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>  <b>4200</b>	
<b>22. I hereby certify that I attended the deceased from</b> <u>9-20-53</u> , 19____, to <u>9-23-53</u> , 19____, that I last saw the deceased alive on <u>9-23-53</u> , 19____, and that death occurred at <u>2:25P</u> m., from the causes and on the date stated above.					
<b>23a. SIGNATURE</b> (Degree or title) <b>Edward P. Blymer M.D.</b>			<b>23b. ADDRESS</b> <b>1515 Lafayette Avenue</b>		<b>23c. DATE SIGNED</b> <b>9-23-53</b>
<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>		<b>24b. DATE</b> <b>9-23-53</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Local Cemetery</b>		<b>24d. LOCATION</b> (City, town, or county) (State) <b>Rat, Missouri.</b>
<b>DATE REC'D BY LOCAL REG.</b> <b>SEP 24 1953</b>		<b>REGISTRAR'S SIGNATURE</b> <b>J. Carl Smith M.D.</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <b>Albert H. Hoppe 4700 Washington.</b>	

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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.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 41940

P. O. Address St. Louis

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.