

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34170

FILED OCT 15 1953

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8820

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 St. Louis		c. LENGTH OF STAY (In this place) 10-days		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
e. STREET ADDRESS 6122 McPherson Ave.		5			
3. NAME OF DECEASED (Type or Print) Mary		a. (First)		b. (Middle) M.	
		c. (Last) Tammany		4. DATE OF DEATH Sept. 9, 1953	
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M.	
8. DATE OF BIRTH June 11, 1880		9. AGE (In years last birthday) 73		10. IF UNDER 1 YEAR Months 2 Days 28	
11. BIRTHPLACE (City and State or Foreign Country) Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13a. FATHER'S NAME William Daniels		13b. MOTHER'S MAIDEN NAME Magdalen Boul		14. NAME OF HUSBAND OR WIFE Stephen C. Tammany	
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. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. Stephen C. Tammany, 6122 McPherson Ave.	

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>Leukemia</u>  ANTECEDENT CAUSES Morbidity 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.		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) <u>204.4</u>	
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 Sept 1, 1953, to Sept 9, 1953, that I last saw the deceased alive on Sept 2, 1953, and that death occurred at 4:50 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>C. W. Womack</u>		(Degree or title) <u>md</u>		23b. ADDRESS <u>539 N. Grand</u>	
23c. DATE SIGNED <u>9-10-53</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept. 12, 1953</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>			
DATE REC'D BY LOCAL REG <u>SEP 11 1953</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. Bonnell</u> <u>700 Lindell Blvd.</u>	

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

9-15-53

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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 me....., Student Embalmer No.....

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  


Licensed Embalmer No. 469

P. O. Address D. Carter

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.