THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 40423

BIRTH NO. NOV 24 1953 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10386

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis, Mo.
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lutheran Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: 2169
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 0
d. STREET ADDRESS (If rural, give location): 16 3107 Chippewa

3. NAME OF DECEASED (Type or Print)
a. (First): Mary Euge
b. (Middle):
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): Oct. 31, 1953

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Apr. 18, 1883
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (City and State or Foreign Country): Missouri 0
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: August Chlanda
13b. MOTHER'S MAIDEN NAME: Rose Wickwak
14. NAME OF HUSBAND OR WIFE: Asa Euge

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: no
17. INFORMANT'S SIGNATURE OR NAME: Asa Euge 3107 Chippewa — ADDRESS

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Peritonitis due to
DUE TO (c) ovarian cyst;

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 216x

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 11:35 m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Patrick E. Taylor, Coroner
23b. ADDRESS: 1300 Clark
23c. DATE SIGNED: 11.2.53

24a. BURIAL, CREMATION, REMOVAL (Specify): removal
24b. DATE: 11-4-53
24c. NAME OF CEMETERY OR CREMATORY: Mt. Olive Cem.
24d. LOCATION (City, town, or county) (State): Lemay 23, Mo.

DATE REC'D BY LOCAL REG.: NOV 2 1953
REGISTRAR'S SIGNATURE: J. Earl Smith MD MJB
25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Southern Funeral Home, 6322 S. Grand Blvd.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT

Coroners office

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 David Van Fossen

Licensed Embalmer No. 4249

P. O. Address 6325 So Grand

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.