

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41326**
Registrar's No. **10832**

FILED NOV 27 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY Missouri		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	
d. FULL NAME OF HOSPITAL OR INSTITUTION Masonic Hospital		d. STREET ADDRESS (If rural, give location) 5351 Delmar	

3. NAME OF DECEASED (Type or Print) Viola		a. (First)		b. (Middle)		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) 11 13 53		
5. SEX Female		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W		8. DATE OF BIRTH 2-27-1866		9. AGE (In years last birthday) 87 if UNDER 1 YEAR 8 Months if UNDER 12 Hrs. 18 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY At home			11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri			12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME Henry Sickman		13b. MOTHER'S MAIDEN NAME Elizabeth Rickman		14. NAME OF HUSBAND OR WIFE George Waldorf	
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 AND ADDRESS Masonic Home of Missouri, 5351 Delmar Subt.	

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) Acute Myocarditis		DUPLICATE OF (b) Chronic Interstitial Nephritis				3 days	
*This does not mean the mode of dying, such as heart failure, athenia, etc. It means the disease, injury, or complication which caused death.		DUPLICATE OF (c) _____				2 Yrs.	
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 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. HOW DID INJURY OCCUR? 592x	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		_____			

22. I hereby certify that I attended the deceased from **10-21-**, 19**51**, to **Nov-13-**, 19**51**, that I last saw the deceased alive on **10-12-**, 19**53**, and that death occurred at **1 A.** m., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i>		(Degree or title) _____		23b. ADDRESS 508 N. Grand Blvd.,		23c. DATE SIGNED 11-13-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11-14-53		24c. NAME OF CEMETERY OR CREMATORY Walhalla Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	

DATE REC'D BY LOCAL REG. NOV 16 1953		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS JAY B. SMITH, Maplewood, Mo.	
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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.....

J. P. Burgess
4029
Maplewood

Licensed Embalmer No.

P. O. Address.....

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.