

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41519**

FILED DEC 10 1953

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **544** Registrar's No. **3094**

1. PLACE OF DEATH a. COUNTY St. Louis County		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before a. STATE Missouri b. COUNTY St. Louis County	
b. CITY (If outside corporate limits, write RURAL and give township) Kirkwood		c. CITY (If outside corporate limits, write RURAL and give township) Kirkwood 4713	
d. FULL NAME OF HOSPITAL OR INSTITUTION 448 W. Adams Ave		d. STREET ADDRESS (If rural, give location) 448 W. Adams Ave	

3. NAME OF DECEASED (Type or Print)	a. (First) Ethel	b. (Middle) Violet	c. (Last) Falker	4. DATE OF DEATH (Month) (Day) (Year) Nov. 30, 1953
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5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 26, 1889	9. AGE (In years) (last birthday) 64	IF UNDER 1 YEAR Months 3	IF UNDER 24 HRS. Hours 3	IF UNDER 15 MIN. Mins.
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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 HOME INDUSTRY Housewife	11. BIRTHPLACE (State or foreign country) Kirkwood Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME William B. Davis	13b. MOTHER'S MAIDEN NAME Lula Dyer	14. NAME OF HUSBAND OR WIFE James Falker Sr.
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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. No.	17. INFORMANT'S SIGNATURE OR NAME James Falker Sr.	ADDRESS 448 W. Adams Ave.
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) arteriosclerotic Heart Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. acute congestive		
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 4200	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **June, 1953** to **Nov 30, 1953** that I last saw the deceased alive on **Nov 30, 1953**, and that death occurred at **5 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Deceased or title) W. W. Alexander M.D.	23b. ADDRESS W. W. Alexander, M.D., St. Louis, Mo.	23c. DATE SIGNED Dec 1-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec. 3, 1953	24c. NAME OF CEMETERY OR CREMATORY Father Dickson	24d. LOCATION (City, town, or county) (State) St. Louis County Mo.
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DATE REC'D BY LOCAL REG. 12-1-53	REGISTRAR'S SIGNATURE Herbert R. Donke M.D.	25. FUNERAL DIRECTOR'S SIGNATURE John W. Hemphill	ADDRESS 408 S. Fillmore Ave.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

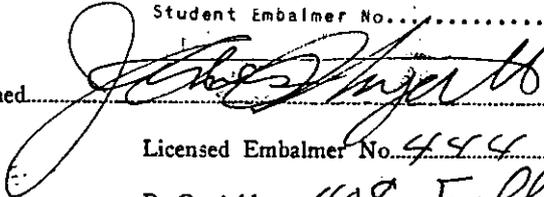
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed.....


Licensed Embalmer No. 4441

P. O. Address 408 Fallin

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.