

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6534
Registrar's No. 1454

BIRTH NO. FILED MAR 4 1954 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>2189</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis Chronic Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>18 4517 Arco Ave.</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Caroline</u> b. (Middle) <u>Lena</u> c. (Last) <u>Marron</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 13, 1954</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Jan. 9, 1877</u>
9. AGE (In years last birthday) <u>77</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo. 0</u>
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Charles Faber</u>		13b. MOTHER'S MAIDEN NAME <u>Christine Kleinseuber</u>	14. NAME OF HUSBAND OR WIFE <u>Robert Dcd.</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>486-12-4841</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Walter Kleinseuber 8951 Argyle Overland</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypertensive arteriosclerotic heart disease</u> INTERVAL BETWEEN ONSET AND DEATH *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. ANTECEDENT CAUSES <u>Rheumatoid arthritis</u> DUE TO (b) <u>Rheumatoid arthritis</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT (Specify) SUICIDE HOMICIDE		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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>443X</u>			
22. I hereby certify that I attended the deceased from <u>N ov. 24, 1953</u> , to <u>Feb. 13, 1954</u> , that I last saw the deceased alive on <u>Feb. 13, 1954</u> , and that death occurred at <u>4:00 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Palmer Rousae Bowditch M.D.</u>		23b. ADDRESS <u>5800 Arsenal St.</u>	
23c. DATE SIGNED <u>2-13-54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>2-16-1954</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Garden</u>		24d. LOCATION (City, town, or county) (State) <u>Wellston, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>FEB 16 1954</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Blummann Bros. Inc. 2504-Woodson Rd-Overland-114-Mo.</u>	

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 *David C. Gibson*.....

Licensed Embalmer No. *345*

P. O. Address *Overland*

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.