

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10168

State File No.

FILED APR 2 1954

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 2804

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY					
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (to this place) 2 wks.		c. CITY OR TOWN St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		e. STREET ADDRESS (If rural, give location) 14 6488 Murdoch					
3. NAME OF DECEASED (Type or Print) a. (First) Ethel		b. (Middle) M.		c. (Last) Joslin			
4. DATE OF DEATH (Month) (Day) (Year) March 26, 1954		5. SEX F		6. COLOR OR RACE W			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Jan. 31, 1889		9. AGE (In years last birthday) 65			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office work		10b. KIND OF BUSINESS OR INDUSTRY Dealers Supply Co.		11. BIRTHPLACE (City and State or Foreign Country) Massachusetts			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Henry Potter		13b. MOTHER'S MAIDEN NAME Florence Salt			
14. NAME OF HUSBAND OR WIFE Robert E. Joslin		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.			
17. INFORMANT'S SIGNATURE OR NAME Dorothy Spangle		ADDRESS 23 Clayton Downs					
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) Posterior Coronary Infarction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) athero sclerosis 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 2 weeks 10 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" 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) 420.1			
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 Jul , 1946, to Mar 26 , 1954, that I last saw the deceased alive on Mar 26, 1954 , and that death occurred at 10:30am. , from the causes and on the date stated above.							
23a. SIGNATURE Lewish (Degree or title) M.D.		23b. ADDRESS 4030 Chouteau		23c. DATE SIGNED 3/27/54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Mar. 29, 1954		24c. NAME OF CEMETERY OR CREMATORY Providence, Rhode Island		24d. LOCATION (City, town, or county) (State) Providence, Rhode Island	
DATE REC'D BY LOCAL REG. MAR 29 1954		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE C. Hoffmeister ADDRESS 6464 Colonial Mortuary, Chippewa			

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

Dr. L. Welsh
4030 Chouteau
Chouteau Bldg.
1:00pm on ?

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 *Lenius C. Hoffmann*

Licensed Embalmer No. 3871

P. O. Address 7814 S.B.

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.