

FILED APR 29 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **13427**  
Registrar's No. **3548**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Saint Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>9 Months</b>		e. STREET ADDRESS (If rural, give location) <b>4029 Shreve Avenue, 15, 2019</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>De Paul Hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>PARALEE</b> b. (Middle) <b>L</b> c. (Last) <b>ELEY FORESTER</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>April 19th, 1954</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, ( ) WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Sept. 20th, 1874</b>	9. AGE (In years last birthday) <b>79</b>	IF UNDER 1 YEAR Months Days	IF UNDER 4 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Charleston, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Levi Forest</b>		13b. MOTHER'S MAIDEN NAME <b>Lucinda Simmons</b>		14. NAME OF HUSBAND OR WIFE <b>George Forester</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Miss Ruth Eley, 4029 Shreve Avenue, 15,</b>		

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:		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>auricular fibrillation</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Myocardial Damage,</b> DUE TO (c) <b>arteriosclerosis, senility</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>malnutrition</b>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <b>450.0</b>
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?

22. I hereby certify that I attended the deceased from **March 14, 1954**, to **April 19, 1954**, that I last saw the deceased alive on **4/17**, 1954, and that death occurred at **11:45 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>John A. Hartung M.D.</b>	23b. ADDRESS <b>2807 N. Grand Blvd</b>	23c. DATE SIGNED <b>4/20/54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>4/22/54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Lenrel Hill Mem. Gardens</b>
24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>		

DATE REC'D BY LOCAL REG. <b>APR 20 1954</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>CALVIN F. FEUTZ, 4828 Natural Bridge Blvd. FUNERAL HOME, INC., St. Louis, 15, Missouri</b>
--	--	---

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..... Signature of Student Embalmer

Signed *Ralph C. Linders*

Licensed Embalmer No. *427*

P. O. Address *St. Louis*

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.