

FILED JUL 2 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **21378**REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5567**

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|---|-------------------------------|--|--|--|---|--|--|
| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | Registrar's No. 5567 | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 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 town) ST. LOUIS, MISSOURI | | c. LENGTH OF STAY (in this place) 6 weeks | | c. CITY OR TOWN St. Louis | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL | | | | e. STREET ADDRESS (If rural, give location) 4135a North Newstead Avenue ²¹⁰⁹ | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) MINNIE | | b. (Middle) _____ | | c. (Last) UNDERWOOD | | 4. DATE OF DEATH (Month) (Day) (Year) JUNE 19, 1954 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | | 8. DATE OF BIRTH Dec. 16, 1865 | | 9. AGE (In years last birthday) 88 If under 1 year: Months _____ Days _____ If under 24 hrs: Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (City and State or Foreign Country) Illinois | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13a. FATHER'S NAME Joe Orr | | 13b. MOTHER'S MAIDEN NAME Emma Wagy | | 14. NAME OF HUSBAND OR WIFE Deceased | | | |
| 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. Unknown | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. J. J. Crehan, 4135a N. Newstead Ave. | | | |
| 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis, Heart Disease DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Undiagnosed Pulmonary disease | | | | INTERVAL BETWEEN ONSET AND DEATH _____ | |
| 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) 4200 | | | |
| 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 5-10-54 , 19____, to 6-19-54 , 19____, that I last saw the deceased alive on 6-19-54 , 19____, and that death occurred at 3:40 P. m. , from the causes and on the date stated above. | | | | | | | |
| 23. SIGNATURE (Degree or title) Martin G. Austin M.D. | | | | 23b. ADDRESS 1515 Lafayette Avenue | | 23c. DATE SIGNED 6-21-54 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE June 22, 1954 | 24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery | | 24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri | | |
| DATE REC'D BY LOCAL REG. JUN 22 1954 | | REGISTRAR'S SIGNATURE Carl Smith MD | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Math Hermann & Son, Inc., 2161 E. Fair Ave | | | |

(Licensed Embalmer's Statement on Reverse Side)

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.....
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.**