

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 6 - 1954

State File No. **24935**
Registrar's No. **7040**

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 24935		Registrar's No. 7040			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____							
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		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 St. John's Hospital				e. STREET ADDRESS (If rural, give location) 16 3617a Tennessee Ave. 21690							
3. NAME OF DECEASED (Type or Print) a. (First) MAE b. (Middle) LOUISE c. (Last) MASSLER			4. DATE OF DEATH Month July Day 28 Year 1954								
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH July 19, 1904		9. AGE (In years last birthday) 50	# UNDER 1 YEAR Months _____	# UNDER 1 YEAR Days _____	# UNDER 1 HR. Hours _____	# UNDER 1 HR. Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper-Butler			10b. KIND OF BUSINESS OR INDUSTRY Bros. Co.		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.			12. CITIZEN OF WHAT COUNTRY? _____			
13a. FATHER'S NAME Charles F. Massler			13b. MOTHER'S MAIDEN NAME Emma W. Fisher			14. NAME OF HUSBAND OR WIFE Ernest W. Brown					
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. None.		17. INFORMANT'S SIGNATURE OR NAME Charles F. Massler		ADDRESS 3617a Tennessee Av					
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) auricular fibrillation with mural thrombi and a ruptured aneurism of the circle of Willis				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.						4 mo.	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				DUE TO (c) _____							
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) _____			
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? 330x							
22. I hereby certify that I attended the deceased from 3-26-54 , 19____, to 7-28-54 , 19____, that I last saw the deceased alive on 7-28-54 , 19____, and that death occurred at 1:15P m., from the causes and on the date stated above.											
23a. SIGNATURE Charles Hugh Neilson (Degree or title) Charles Hugh Neilson M.D.				23b. ADDRESS 539 N. Grand Av. St. Louis, Mo			23c. DATE SIGNED 7-29-54				
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE July 31, 1954	24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.						
DATE REC'D BY LOCAL REG. JUL 29 1954		REGISTRAR'S SIGNATURE [Signature]			25. FUNERAL DIRECTOR'S SIGNATURE Kriegshauser ADDRESS 4228 S. Kingshighway Bl.						

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 *Richard W. Storvick*.....

Licensed Embalmer No. *400*.....

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.