

FILED SEP 28 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32567**
Registrar's No. **2132**

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|---|--|---|---|--|---|---|---|
| BIRTH NO. _____ | | REG. DIST. NO. 317 | | PRIMARY REG. DIST. NO. 547 | | Registrar's No. 2132 | |
| 1. PLACE OF DEATH a. COUNTY St. Louis | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois b. COUNTY Madison | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) Richmond Heights | | c. LENGTH OF STAY (in this place) 2 weeks | | c. CITY (If outside corporate limits, write RURAL and give township) Granite City | | 812 1/2 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Marys Hospital | | | | d. STREET ADDRESS (If rural, give location) RR #1 Box 1003 | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Sallie | | | b. (Middle) Ann | | c. (Last) Selph | | 4. DATE OF DEATH (Month) (Day) (Year) Sept. 5 1954 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH May 30, 1887 | 9. AGE (In years last birthday) 67 | IF UNDER 1 YEAR Months | IF UNDER 12 HRS. Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (City and State or Foreign Country) Tennessee | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13a. FATHER'S NAME Unknown | | 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE Benjamin Selph | | | |
| 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 AND ADDRESS Benjamin Selph RR #1 Box 1003 Granite City, Ill | | | |
| 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) Acute Systolic heart failure | | | | | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Hepatic, Gallstones | | | | | | 3 days |
| | DUE TO (c) Arteriosclerosis, hypertension | | | | | | |
| | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. (diabetes) | | | | | | |
| 19a. DATE OF OPERATION 9/5/54 | | 19b. MAJOR FINDINGS OF OPERATION none - heart stopped - massaged heart 42:00 | | | | | 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.) Richmond Heights, Mo | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Richmond Heights Mo | | | |
| 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? none | | | |
| 22. I hereby certify that I attended the deceased from Sept 3, 1954 , to Sept 5, 1954 , that I last saw the deceased alive on Sept 5, 1954 , and that death occurred at 5:20 P.M. , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE L. O. Greer, M.D. (Degree or title) | | | | 23b. ADDRESS 504 N. Grand St. Louis | | 23c. DATE SIGNED 9/7/54 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 9-5-1954 | 24c. NAME OF CEMETERY OR CREMATORY Moope Cemetery | | 24d. LOCATION (City, town, or county) (State) Bear Springs, Tennessee | | |
| DATE REC'D BY LOCAL REG. 9/7/54 | | REGISTRAR'S SIGNATURE Herbert R. ... | | 25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Frank Mercer Granite City, Ill | | | |

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
Student Embalmer

Signed Charles E. Merce

Licensed Embalmer No. 2988

P. O. Address Grants City, Mo.

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 this body is not embalmed, fact should be so stated above.