

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35627**
Registrar's No. **8772**

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 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) 9 dys		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION: ST. LOUIS CHRONIC HOSPITAL		e. STREET ADDRESS (If rural, give location) 6180 Pershing Ave			
3. NAME OF DECEASED (Type or Print) a. (First) Maria b. (Middle) c. (Last) Leo			4. DATE OF DEATH (Month) (Day) (Year) Sept. 24, 1954.		
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow	8. DATE OF BIRTH May 1, 1872		9. AGE (In years last birthday) 82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Italy	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Peter Pipa		13b. MOTHER'S MAIDEN NAME Monica ??		14. NAME OF HUSBAND OR WIFE =	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Mary Rittel 6180 Pershing Ave.		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardio Vascular Disease		DUPLICATE OF (b) with chronic Brain Syndrome.			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUPLICATE OF (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing 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)			
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? 443x			

22. I hereby certify that I attended the deceased from **Sept. 15, 1954**, to **Sept. 24, 1954**, that I last saw the deceased alive on **Sept. 24, 1954**, and that death occurred at **10:00 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Palmer Romanus Bowditch M.D.		23b. ADDRESS 5800 Arsenal St.		23c. DATE SIGNED 9-25-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE SEPT. 28, 1954	24c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEMETERY	24d. LOCATION (City, town, or county) (State) ST. LOUIS, MISSOURI		
DATE REC'D BY LOCAL REG. SEP 27 1954	REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STROOT & CARROLL 4600 NATURAL BRIDGE		

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 *M. W. R. P. M. T. C.*

Licensed Embalmer No. *486*

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.