

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 39757

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 2431

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY OR TOWN <u>MANCHESTER, Mo.</u> c. LENGTH OF STAY (in this place) <u>2 Mo.</u>		c. CITY OR TOWN <u>KIRKWOOD, Mo.</u> d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>MANCHESTER NURSING HOME</u>		* STREET ADDRESS (If rural, give location) <u>656 EAST JEFFERSON</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>MATHILDA</u> b. (Middle) <u>TILLIE</u> c. (Last) <u>PULLEN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>OCT. 18 1954</u>		
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5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>DIVORCED</u>		8. DATE OF BIRTH <u>JAN 10 1886</u>		9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>				11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			

13a. FATHER'S NAME <u>CHARLES SOMMERHAUSER</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			14. NAME OF HUSBAND OR WIFE <u>JOSEPH PULLEN (DECD)</u>		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <u>MATHILDA SHELTON, Kirkwood Mo</u>			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH <u>one year</u>	
<p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Ovarian Carcinoma &amp; Metastases</u>							
		ANTECEDENT CAUSES							
		MORBID CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last.							
		DUE TO (b) _____							
		DUE TO (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 <u>175X</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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) (Min.)		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 4/10 1950 to OCT 18, 1954, that I last saw the deceased alive on OCT 18, 1954, and that death occurred at 5 AM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Raymond M. Charney M.D.</u>		23b. ADDRESS <u>634 N. Grand</u>		23c. DATE SIGNED <u>10/18/54</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>OCT 19 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>VALHALLA CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>	
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DATE REC'D BY LOCAL REG. <u>10/19/54</u>		REGISTRAR'S SIGNATURE <u>Hester L. Somers</u>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>Thomas Curtis 2906 Georgia</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

214  
430

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.....  
*Samuel E. Hill*

Licensed Embalmer No. *4347*

P. O. Address *2906 Jan*

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.