

FILED DEC 17 1954

STANDARD CERTIFICATE OF DEATH

State File No. **42526**

Registrar's No. **11091**

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).	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		a. STATE MO	
c. LENGTH OF STAY (In this place)		b. COUNTY	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1455 O'Fallon		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
		d. STREET ADDRESS (If rural, give location) 25 1455 O'Fallon	

3. NAME OF DECEASED (Type or Print)	a. (First) Noor	b. (Middle)	c. (Last) Khan	4. DATE OF DEATH (Month) (Day) (Year)
				Nov. 30, 1954

5. SEX Female	6. COLOR OR RACE Wrest Indian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3-7-1893	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Days	IF UNDER 12 MIN. Hours	Min.
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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 (State or foreign country) Deada Ala	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Omar Khan
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Omar Khan	ADDRESS 1455 O'Fallon
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Nephritis		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Decubitus Ulcers		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 446x
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22. I hereby certify that I attended the deceased from 11-1, 1954 to 11-30, 1954, that I last saw the deceased alive on 11-29, 1954, and that death occurred at 9:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE X A. K. ...	(Degree or title)	23b. ADDRESS 1417 Franklin	23c. DATE SIGNED 12-4-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 12-7-1954	24c. NAME OF CEMETERY OR CREMATORY Oakdale Cem.	24d. LOCATION (City, town, or county) (State) St. Louis County MO
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DATE REC'D BY LOCAL REG. DEC 6 1954	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Husinda Thomas	ADDRESS 2824 Cass
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S.P. (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
Student Embalmer

Signed *Leroy W. Gannister*

Licensed Embalmer No. *4523*

P. O. Address *3880 Exton Ave*

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.