

FILED MAR 31 1955

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BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
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 town) St. Louis		c. LENGTH OF STAY (in this place) township)		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Lukes Hospital				STREET ADDRESS (If rural, give location) 12 5351 Delmar 2129			
3. NAME OF DECEASED (Type or Print) Almeda		a. (First)		b. (Middle) Dean		c. (Last)	
4. DATE OF DEATH March 14, 1955		5. SEX F		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH Jan. 9, 1863		9. AGE (In years last birthday) 92yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (City and State or Foreign Country) Fairfield, Ohio	
10b. KIND OF BUSINESS OR INDUSTRY Housewife		12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Louis Dean		13b. MOTHER'S MAIDEN NAME Lydia Margaret Berry	
13c. NAME OF HUSBAND OR WIFE Taylor Dean		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 Masonic Home of Missouri 5351 Delmar	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac arrest  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Long standing decompensation DUE TO (c) Fall at Home - Fracture, left hip  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fracture, left hip  20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION 3/13/55		19b. MAJOR FINDINGS OF OPERATION Fr left hip				21. HOW DID INJURY OCCUR? See above E9040	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) St. Louis MO		(STATE)	
21d. TIME OF INJURY 3-13-55 m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22. I hereby certify that I attended the deceased from 3/13/1955, to 3/14, 1955, that I last saw the deceased alive on 3/14, 1955, and that death occurred at 10 P.M., from the causes and on the date stated above. 21			
23a. SIGNATURE Earl P. Holt, Jr M.D.		(Degree or title)		23b. ADDRESS 3720 Washington		23c. DATE SIGNED Mar, 17, '55.	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE March 17, 1955		24c. NAME OF CEMETERY OR CREMATORY Lakewood Park Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.	
DATE REC'D BY LOCAL REG. MAR 17 1955		REGISTRAR'S SIGNATURE J. Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Hearsh & Sons 6/75 Old			

WRITE PLAINLY—USING UNFADEING 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..... *Jos. E. McCulloch*

Licensed Embalmer No. *246*

P. O. Address..... *61507*

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.