

FILED MAR 31 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10323**
2102
Registrar's No.

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 MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN ST LOUIS
d. FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN Hosp.		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS (If rural, give location) 24 2218 MIAMI St.		22990	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) Louise	b. (Middle) C. VALENTINE	c. (Last)	3-5-55		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 7-2-1895	9. AGE (In years last birthday) 59	if UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Belleville, Ill	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Henry JANSON			
13b. MOTHER'S MAIDEN NAME Augusta Neubarth		14. NAME OF HUSBAND OR WIFE Charles			

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.		17. INFORMANT'S SIGNATURE OR NAME August Janson Kevin Barabas Rd ADDRESS 621	
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brain tumor (glioma)		INTERVAL BETWEEN ONSET AND DEATH ?
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last. 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	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.)	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? 193X

22. I hereby certify that I attended the deceased from **MARCH 1, 1955**, to **MARCH 5, 1955**, that I last saw the deceased alive on **MARCH 5, 1955**, and that death occurred at **3:10 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE August V. Kinschel M.D. (Degree or title)	23b. ADDRESS 620 Hoffman Ave	23c. DATE SIGNED 3/7/55
24a. BURIAL, CREMATION, OR REMOVAL (Specify)	24b. DATE 2-8-55	24c. NAME OF CEMETERY OR CREMATORY Oak Grove
24d. LOCATION (City, town, or county) (State) St Louis Co. Mo		

DATE REC'D BY LOCAL REG. MAR 7 1955	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Arthur L. G. Co ADDRESS 2707 1/2 Grand
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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 *Hadley P. Jaellon Jr*
Licensed Embalmer No. 4950

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.