

FILED MAY 9 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13318**
Registrar's No. **3491**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY, (in this place) 5 days	c. CITY OR TOWN Hanley Hills		d. In 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			e. STREET ADDRESS (If rural, give location) 1912 Larch		
3. NAME OF DECEASED (Type or Print) a. (First) NELLIE		b. (Middle)	c. (Last) FORSTER	4. DATE OF DEATH (Month) (Day) (Year) April 18, 1955	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Nov. 5, 1885	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Home maker	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Dennis Connors		13b. MOTHER'S MAIDEN NAME Mary Doyle		14. NAME OF HUSBAND OR WIFE Michael E. Forster	
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. 489-05-6672	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Michael Forster 1912 Larch Dr.		
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, asthma, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumococcus Meningitis ANTECEDENT CAUSES otitis media Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 6 days 7 "
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) no		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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 3910		
22. I hereby certify that I attended the deceased from 4/13 , 19 55 , to 4/18 , 19 55 that I last saw the deceased alive on 4/17 , 19 55 and that death occurred at 9 a m., from the causes and on the date stated above.					
23a. SIGNATURE Paul O. Hagemann M.D.		23b. ADDRESS 3720 Washington		23c. DATE SIGNED 4/19/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/21/55	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis Mo.		
DATE REC'D BY LOCAL REG. APR 19 1955		REGISTRAR'S SIGNATURE J. C. Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McCullen Kelly 7267 Natural Bridge		

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 *James A. Lamm*.....

Licensed Embalmer No. *411*
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.