

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 27 1955

BIRTH NO. _____ REG. DIST. NO. **717** PRIMARY REG. DIST. NO. **500** Registrar's No. **879**

1. PLACE OF DEATH a. COUNTY St. Louis			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 Robertson		c. LENGTH OF STAY (In this place) 6 weeks	c. CITY (If outside corporate limits, write RURAL and give township): OR TOWN Kirkwood 717		
d. FULL NAME OF HOSPITAL OR INSTITUTION Carter Nursing Home			d. STREET ADDRESS (If rural, give location) 404 S. Harrison		

3. NAME OF DECEASED (Type or Print) MAGGIE	a. (First)	b. (Middle) AITCH	c. (Last)	4. DATE OF DEATH 4-13-1955
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 19, 1884	9. AGE (In years; if under 1 year last birthday) 70	if UNDER 1 YEAR Months _____ Days _____	if UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (City and State or Foreign Country) St. Louis Co. Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Frank Standard	13b. MOTHER'S MAIDEN NAME Elizabeth Lewis	14. NAME OF HUSBAND OR WIFE George Aitch
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. None	17. INFORMANT'S SIGNATURE OR NAME Howard Aitch ADDRESS 358 S. Taylor

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Uterus	DUPLICATE OF (b) _____		2 months
ANTECEDENT CAUSES	DUPLICATE OF (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION None	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) None	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 176x
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) None	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? None

22. I hereby certify that I attended the deceased from **2-15, 1955**, to **4-13, 1955**, that I last saw the deceased alive on **4-13, 1955**, and that death occurred at **3:15 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Maxie S. Albrecht MD	23b. ADDRESS 826 N. Channing St. Louis	23c. DATE SIGNED 4-15-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 4/18/1955	24c. NAME OF CEMETERY OR CREMATORY Moselle Cemetery	24d. LOCATION (City, town, or county) (State) St. Clair, Missouri
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DATE REC'D BY LOCAL REG. 4/16/55	REGISTRAR'S SIGNATURE Hebeal R. Sombert	25. FUNERAL DIRECTOR'S SIGNATURE Charles J. Gates ADDRESS 4107 Finney Ave
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(Licensed Embalmer) (Statement on Reverse Side)

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

filed 4

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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address. 1107 Finney Avenue

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.