

No. 300  
10.48

FILED MAY 17 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 17198

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 542 Registrar's No. 1006

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b>		b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>FERGUSON</b>		c. CITY OR TOWN <b>Normandy</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (In this place) <b>2 1/2 Months</b>		STREET ADDRESS (If rural, give location) <b>7416 Augusta Avenue</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Oak Knoll Nursing Home</b>					

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <b>MYRTLE</b>	b. (Middle) <b>HELENA</b>	c. (Last) <b>BRITT</b>	<b>: 5 1 55</b>		

5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>never married</b>	8. DATE OF BIRTH <b>Aug. 21, 1886</b>	9. AGE (In years last birthday) <b>68</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	Min.
----------------------	-------------------------------	-----------------------------------------------------------------------------	---------------------------------------	-------------------------------------------	------------------------	------------------------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>House work</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
------------------------------------------------------------------------------------------------------------	-----------------------------------------------------	-------------------------------------------------------------------------------	-----------------------------------------

13a. FATHER'S NAME <b>Thomas C. Britt</b>	13b. MOTHER'S MAIDEN NAME <b>Helena Manz</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
-------------------------------------------	----------------------------------------------	-----------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>no</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Bessie C. Wortmann-7416 Augusta Avenue</b>	ADDRESS
--------------------------------------------------------------------------------------------------------------------	-----------------------------------	---------------------------------------------------------------------------------	---------

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Congestive Heart Failure</b>		<b>1 month</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Rheumatic Heart Disease</b> DUE TO (c) <b>Rheumatic Mitral and aortic stenosis</b>		<b>10 yrs</b>
H. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<b>10 yrs</b>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>None</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <b>3 11</b>	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
-------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------	----------------------------

22. I hereby certify that I attended the deceased from Jan 19 50, to May 1, 19 55, that I last saw the deceased alive on April 30 19 55 and that death occurred at 11:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE <b>James F. Murphy, M.D.</b>	22b. ADDRESS <b>607 North Grand Blvd.</b>	22c. DATE SIGNED <b>5-2-55</b>
---------------------------------------------	-------------------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24b. DATE <b>5-4-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>
---------------------------------------------------------	-------------------------	--------------------------------------------------------------	---------------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. <b>5/2/55</b>	REGISTRAR'S SIGNATURE <b>Richard P. Blomker, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>C. R. Lupton &amp; Sons-7233 Dekmar Blv'd.</b>	ADDRESS
----------------------------------------	-------------------------------------------------------	------------------------------------------------------------------------------------	---------

(Licensed Embalmer's Statement on Reverse Side)

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

209  
4

g.s.

10-5  
1550

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 *Clarence A. Murray*

Licensed Embalmer No. *4011*

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.