

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20284**
REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4942**

FILED JUN 22 1955

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	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Little Sisters of Poor		e. STREET ADDRESS (If rural, give location) 3400 S. Grand Blvd. 21690	
3. NAME OF DECEASED (Type or Print) Mary		4. DATE OF DEATH (Month) (Day) (Year) June 5, 1955	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH January 15, 1882	
9. AGE (In years last birthday) 73		10. IF UNDER 1 YEAR Months 4 Days 20 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo. 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Daniel O'Conner		13b. MOTHER'S MAIDEN NAME Annie Martin	
14. NAME OF HUSBAND OR WIFE Joseph		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Sister Henry 3400 S. Grand Blvd.	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Dis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Sen. Arteriosclerosis 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 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) St Louis Mo	
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? 4200		22. I hereby certify that I attended the deceased from Jan 1955 , to 6/5/55 , 19___, that I last saw the deceased alive on 6/3/55 , 19___, and that death occurred at 3 Pm m., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) J. Arroyo M.D.		23b. ADDRESS 539 N. Grand	
23c. DATE SIGNED 6/6/55		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 6/7/55		24c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis Mo.		25. FUNERAL DIRECTOR'S SIGNATURE John H. Gebken Sons	
DATE REC'D BY LOCAL REG. JUN 6 1955		REGISTRAR'S SIGNATURE J. Carl Smith M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE John H. Gebken Sons		ADDRESS 2630 Gravois Ave.	

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 *Robert F. Gebken*

Licensed Embalmer No. **4144**

P. O. Address **2630 Gravois**

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.