

FILED AUG 2 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23560
State File No.

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 6277

BIRTH NO. _____

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) <u>ST. LOUIS</u>	c. LENGTH OF STAY (in this place) <u>28 Days</u>	c. CITY OR TOWN <u>ST. LOUIS</u>	d. Is 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 <u>ST. LOUIS CHRONIC HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>4747 Thrush Avenue</u> 2079	

3. NAME OF DECEASED (Type or Print) a. (First) <u>MARIAN</u> b. (Middle) <u>LOUISE</u> c. (Last) <u>CAPRA</u>	4. DATE OF DEATH (Month) <u>7</u> (Day) <u>19</u> (Year) <u>1955</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec 4 1900</u>	9. AGE (In years last birthday) <u>54</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Lady</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FAMMUIS BARR.</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Indiana</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			

13a. FATHER'S NAME <u>Dwight Simmons</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret Pullis</u>	14. NAME OF HUSBAND OR WIFE <u>John Capra</u>
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 <u>John Capra</u>
		ADDRESS <u>4747 Thrush ave</u>

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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>BRAIN TUMOR - TYPE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 MONTHS</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>UNKNOWN</u>		
	DUE TO (c) <u>TERMINAL PNEUMONIA</u>		

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)
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?

22. I hereby certify that I attended the deceased from June 22, 1955, to July 19, 1955, that I last saw the deceased alive on July 19, 1955, and that death occurred at 1:10 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>George M. Tanaka, M.D.</u>	(Degree or title)	23b. ADDRESS <u>5600 Arsenal St.</u>	23c. DATE SIGNED <u>7/19/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>7/22/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u>
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DATE REC'D BY LOCAL REG. <u>JUL 21 1955</u>	REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>John Stygar & Son Funeral Home</u>	ADDRESS <u>5541 Riverview Blvd</u>
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Embalmer's Statement on Reverse Side

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.....

Licensed Embalmer No. 390

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.