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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 21 1955

State File No.

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 544 Registrar's No. 1504

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirkwood Mo.</u>	c. LENGTH OF STAY (in this place) <u>2 months</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. Joseph Hospital</u>		STREET ADDRESS (If rural, give location) <u>1025 Grandview Place</u> <u>20491</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Anna</u> b. (Middle) _____ c. (Last) <u>Volas</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>7 1 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>9/18/87</u>	9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>13</u>	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Felix A. Bequette</u>	13b. MOTHER'S MAIDEN NAME <u>UNK. Doll</u>	14. NAME OF HUSBAND OR WIFE <u>Peter Volas</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Peter Volas</u>	ADDRESS <u>1025 Grandview Place St. Louis</u>
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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 <u>5 weeks</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic vascular disease</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Rt. leg amputated due to Paget's disease</u>		19. DATE OF OPERATION _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>331X</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	

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 checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from June, 1954, to July, 1955, that I last saw the deceased alive on July, 1955, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE <u>D. Deabough</u>	(Degree or title) _____	23b. ADDRESS <u>M. D. Webster, Groves Mo.</u>	23c. DATE SIGNED <u>7/3/55</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>7/5/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Genevieve Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Genevieve Mo.</u>

DATE REC'D BY LOCAL REG. <u>7/2/55</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Donta</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>M. J. Donnelly</u>	ADDRESS <u>3840 Linden Blvd</u>
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(Licensed Embalmers' Statement on Reverse Side)

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

Dr. O. A. Lockwood 8-10
105 W. Lockwood

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 *Francis Williams*

Licensed Embalmer No. 35

P. O. Address 3840

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (E 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.