

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27577

FILED SEP 6 1955

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7122

1. PLACE OF DEATH a. COUNTY		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) OR TOWN <u>St. Louis, Mo</u>		c. CITY OR TOWN <u>St. Louis, Mo</u> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (In this place)		6. STREET ADDRESS <u>4754-A Maffitt Ave</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>City Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Emma</u> b. (Middle)		c. (Last) <u>Dailey</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 12, 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>Sept 30, 1870</u>		9. AGE (In years last birthday) <u>84</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of last year, or if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo</u>	
<u>Housewife</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>	

13a. FATHER'S NAME <u>Joseph Swacina</u>		13b. MOTHER'S MAIDEN NAME <u>Annie Calhoun</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased Derek</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>Ida Schlereck</u>	
				ADDRESS <u>4754 Maffitt Ave</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Amputation of Left Leg;</u> ANTECEDENT CAUSES <u>Dilateral Hydrothorax;</u> <u>Generalized Arteriosclerosis</u> DUE TO (b) <u>(Non-Traumatic)</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>450.0</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Min.)		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 \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 8:40 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>James M. Kelly</u> Registrar (Name or title)		23b. ADDRESS <u>1300 Clark</u>		23c. DATE SIGNED <u>8.15.55</u>	
---	--	-----------------------------------	--	------------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug 16, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem</u>	
				24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo</u>	

DATE REC'D BY LOCAL REG. <u>AUG 15 1955</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Sullivan's Funeral Directors</u>	
				ADDRESS <u>2849 N. Euclid</u>	

(Licensed 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 *Albert Mayfield*.....

Licensed Embalmer No. *30*.....

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.