

FILED NOV 23 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38739

State File No.

9980

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. _____	
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 town) <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>20 yrs.</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>Park Lane Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>3725 California Avenue 2249</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARY</u>		b. (Middle) <u>VENITA</u>		c. (Last) <u>POPP</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 13 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>July 17, 1897</u>	
9. AGE (In years last birthday) <u>58 yrs.</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Household</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>E. St. Louis, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John McGarey</u>			13b. MOTHER'S MAIDEN NAME <u>Celestine Valentine</u>			14. NAME OF HUSBAND OR WIFE <u>Mr. Charles B. Popp</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mr. Charles B. Popp, 3725 California 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Intestinal Obstruction</u> ANTECEDENT CAUSES DUE TO (b) <u>multiple post-operative adhesions</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 _____				20. AUTOPSY? YES <input 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) <u>570.5</u>			
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 <u>October 27 19 55</u> , to <u>Nov 13</u> , 1955, that I last saw the deceased alive on <u>Nov 13</u> , 1955, and that death occurred at <u>5:30 p m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Wm. J. Smith M.D.</u>				23b. ADDRESS <u>PARK LANE MEMORIAL HOSPITAL, 4936 Lindell Blvd. St. Louis 8</u>		23c. DATE SIGNED <u>11-14-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov. 16, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Trinity Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>NOV. 16 1955</u>		REGISTRAR'S SIGNATURE <u>Wm. J. Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave.</u>			

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

(Licensed Embalmer's Statement on Reverse Side)

Will be at Hospital all afternoon
Will sign certificate there.

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 _____
David Rossell

Licensed Embalmer No. 45

P. O. Address A. S. ...

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