

FILED NOV 29 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **39234**

BIRTH NO. _____		REG. DIST. NO. <b>317</b>		PRIMARY REG. DIST. NO. <b>547</b>		Registrar's No. <b>2618</b>			
1. PLACE OF DEATH a. COUNTY <b>St Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo</b> COUNTY <b>St Louis</b>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Richmond Hgte</b>				c. LENGTH OF STAY (in this place) <b>2 wks</b>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St Marys Hosp</b>				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Creve Coeur 730</b>					
				d. STREET ADDRESS (If rural, give location) <b>Olive &amp; Denver La</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>Flora</b>			b. (Middle) <b>Westfall</b>		c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) <b>Nov 6 1955</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>June 5 1895</b>	9. AGE (In years last birthday) <b>60</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 10 HRS. Hours _____ Mins. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Fredericktown Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13a. FATHER'S NAME <b>Aug. D. Villars</b>			13b. MOTHER'S MAIDEN NAME <b>Sallie DeGuire</b>		14. NAME OF HUSBAND OR WIFE <b>Dr Paul M Westfall</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Dr Paul M Westfall Creve Coeur Mo</b>					
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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Thrombosis</b>				INTERVAL BETWEEN ONSET AND DATE OF DEATH <b>10/22/55</b>	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis</b>					
				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 <b>4500</b>				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)					
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 <b>Oct 22</b> , 19 <b>55</b> , to <b>Nov 6</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>Nov 6</b> , 19 <b>55</b> , and that death occurred at <b>6:05 P.m.</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>Walter Moore</b>				23b. ADDRESS <b>M.D. 6376 Clayton</b>		23c. DATE SIGNED <b>11/7/55</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>11/9/55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St Monica</b>		24d. LOCATION (City, town, or county) (State) <b>Creve Coeur Mo</b>			
DATE REC'D BY LOCAL REG. <b>11-8-55</b>		REGISTRAR'S SIGNATURE <b>Hubert R. Dombke M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Ortmann F Home Overland Mo</b>					

87.

(Licensed Embalmer's Statement on Reverse Side)

**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 .....

Student Embalmer

Signed Al C. Ostmann

Licensed Embalmer No. 3478

P. O. Address.....

**Note:** The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.