

No. 300  
10.48

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42743

FILED JAN 11 1956

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

318

1003

Registrar's No. 11178

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. 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 <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis 12, Mo</u>	c. LENGTH OF STAY (In this place) <u>7 DAYS</u>	c. CITY OR TOWN <u>4462 Clayton (5)</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>111 Aberdeen Pl.</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>MARGARET</u>	b. (Middle) <u>MANDEVILLE</u>	c. (Last) <u>WARNER</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>12 20 1955</u>
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>8-7-89</u>	9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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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>OWN Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Utica, N. Y.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Charles Mandeville</u>	13b. MOTHER'S MAIDEN NAME <u>Ellen Carmody</u>	14. NAME OF HUSBAND OR WIFE <u>MONROE</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>121-12-2139</u>	17. INFORMANT'S SIGNATURE OR NAME <u>MR. M. F. WARNER</u>	ADDRESS <u>- 111 ABERDEEN PL.</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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</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>General arterio-sclerosis</u> 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 <u>331x</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from Aug, 1945, to Dec. 20, 1955, that I last saw the deceased alive on Dec. 20, 1955, and that death occurred at 9:55 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Anthony B. Day</u> <u>William B. Day, M.D.</u>	(Degree or title)	23b. ADDRESS <u>3720 Washington</u>	23c. DATE SIGNED <u>12-20-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal (RAIL)</u>	24b. DATE <u>12-22-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>LAKEWOOD CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>MINNEAPOLIS, MINN.</u>
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DATE REC'D BY LOCAL REG. <u>DEC 21 1955</u>	REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Alexander &amp; Sons, Inc.</u>	ADDRESS <u>6175 Delmar Bur</u>
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(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 *Joe E McEulloch*

Licensed Embalmer No. *246*

P. O. Address *61755*

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