

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25020

State File No.

FILED JUL 20 1956

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6452**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2044 HARRIS AVE		e. STREET ADDRESS (If rural, give location) 2044 HARRIS AVE	
3. NAME OF DECEASED (Type or Print) Josephine		4. DATE OF DEATH (Month) (Day) (Year) 7-9-56	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH 12-8-1868	
9. AGE (In years last birthday) 87		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Fred Le Roy		13b. MOTHER'S MAIDEN NAME Not known	
14. NAME OF HUSBAND OR WIFE John T Hewitt			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, if so, unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME John W. Hoffman		ADDRESS 7644 Lynn	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocarditis arterio-sclerotic Myocarditis, arteriosclerosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (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	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		722-1	
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? June to 9th July			
22. I hereby certify that I attended the deceased from June , 1956, to July , 1956, that I last saw the deceased alive on July 9 , 1956, and that death occurred at just m., from the causes and on the date stated above.			
23a. SIGNATURE Ralph Riley		23b. ADDRESS No. Theatre Bldg	
23c. DATE SIGNED JUL 10 1956			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7-12-56	
24c. NAME OF CEMETERY OR CREMATORY Calvary		24d. LOCATION (City, town, or county) (State) St Louis Mo	
DATE REC'D BY LOCAL REG. JUL 10 1956		REGISTRAR'S SIGNATURE Carl Smith	
25. FUNERAL DIRECTOR'S SIGNATURE W.C. 2707 N. Grand		ADDRESS	

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

Gustav W. Dietrich

Licensed Embalmer No. *432*

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.