

FILED SEP 21 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32256**
Registrar's No. **7820**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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. LENGTH OF STAY (in this place) 1 day	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony's Hospital		e. STREET ADDRESS (If rural, give location) 3108a N. 21st Street	

3. NAME OF DECEASED (Type or Print) a. (First) Alice b. (Middle) Margaret c. (Last) Middendorf		4. DATE OF DEATH (Month) (Day) (Year) 8 - 22 - 1956	
5. SEX Fem	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 9 - 6 - 1920
9. AGE (In years last birthday) 35		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Keith	

13b. MOTHER'S MAIDEN NAME Margaret Mc Collum		14. NAME OF HUSBAND OR WIFE William H. Middendorf	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Wm. H. Middendorf
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION		ADDRESS 3108a N. 21st St.	

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Polio. Bulbar.		INTERVAL BETWEEN ONSET AND DEATH 8.14.56
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		
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 080.0	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) (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 **9-16**, 19**56** to **9-22**, 19**56** that I last saw the deceased alive on **9-22**, 19**56** and that death occurred at **11:40 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Clarence E. Drenn	(Degree or title) M.D.	23b. ADDRESS 1927 A Union	23c. DATE SIGNED 9-22-56
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 8/25/56	24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County Mo.

DATE REC'D BY LOCAL REG. AUG 23 1956	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Drehmann-Harral	ADDRESS 1905 Union Blvd.
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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 *Warren A. Carver*.....

Licensed Embalmer No. *353*.....

P. O. Address.....

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.