

FILED NOV 29 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39681

STATE FILE NUMBER

 Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10328**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital #1				Length of stay in lb 26 9		STREET ADDRESS (If outside, give location) 5217 Northland		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Emma Middle Elizabeth Last Noel				4. DATE OF DEATH Month November Day 10 Year 1956				
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-26-1870		9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months 8 Days 6 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Calant Endicott				14. MOTHER'S MAIDEN NAME Elizabeth Reister				
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 Engenia Fenton Address 5247 Northland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation due to aspiration of food							INTERVAL BETWEEN ONSET AND DEATH 5 min	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral vascular accident							2 mo.	
DUE TO (c) 331X								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour 11:55a Month 11 Day 10 Year 1956 a. m. 11:55 p. m.								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		20g. COUNTY STATE		
21. I attended the deceased from 9-14-56 to 11-10-56 and last saw her face alive on 11-10-56 Death occurred at 11:55a m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE Alan H. Johnson M.D. (Name or title)				22b. ADDRESS 1515 Lafayette		22c. DATE SIGNED 11/13/56		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11-13-1956	23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.			
24. FUNERAL DIRECTOR Dachmann Harrel ADDRESS 1905 Union			25. DATE RECD. BY LOCAL REG. NOV 13 1956		26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. m. J. B.			

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be treated as diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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. *39*.....

P. O. Address

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