

Health,
Welfare
Public
Service

300
-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All 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

FILED NOV 26 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

40189

Registration District No. 312 Primary Registration District No. 500 Registrar's No. 2415

1. PLACE OF DEATH a. COUNTY <u>St. Louis,</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Arbor Terrace</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Louis,</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mother Of Good Counsel Home, 9th Mo</u>				Length of stay in lb		STREET ADDRESS (If outside, give location) <u>6340 Devonshire</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Bertha</u> Last <u>Krater</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>14,</u> Year <u>1956</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 14, 1880</u>		9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u> Hours <u>14</u> Min.
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>At Home</u>		11. BIRTHPLACE (City and state or country) <u>Perryville, Missouri.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Samuel Ellis</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Manning</u>				
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>Nil.</u>		17. INFORMANT <u>Cletus Krater, 6340 Devonshire</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>4200</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hemiplegia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6-240</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>						
20c. TIME OF INJURY Hour <u>none</u> Month <u>none</u> Day <u>none</u> Year <u>none</u>								
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.) <u>none</u>		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. I attended the deceased from <u>July 56.</u> to <u>Oct 14, 56</u> last saw her/him alive on <u>Oct 14, 56</u> Death occurred at <u>6</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>M. D. Stahl</u>				22b. ADDRESS <u>7124 Natural Bridge</u>		22c. DATE SIGNED <u>Oct 15, 56</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10-15-56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Local Catholic Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Perryville, Missouri.</u>			
24. FUNERAL DIRECTOR <u>Albert H. Hoppe 4700 Washington,</u>			25. DATE RECD. BY LOCAL REG. <u>10-15-56</u>		26. REGISTRAR'S SIGNATURE <u>Herbert B. Donke MD</u>			

(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.....
Signature of Student Embalmer

Signed *Elton R. Remelius*.....

Licensed Embalmer No. *42*.....

P. O. Address *St. Louis*.....

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.