

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14329

STATE FILE NUMBER

FILED DEC 20 1956

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2870

health, Welfare public service  
 300  
 1-66  
 ATTENTION: NO symptoms were listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION

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 <u>St. Louis</u>							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rock Hill, 17,</u>		Inside Limits- Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kirkwood 4793,</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rock Hill Nursing</u>			Length of stay in lb <u>12 days</u>		d. STREET ADDRESS (If outside, give location) <u>455 South Holmes</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>M.</u> Last <u>MURCH</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>3rd</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>June 2, 1871</u>		9. AGE (In years last birthday) <u>85</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph Davis</u>						14. MOTHER'S MAIDEN NAME <u>Martha M. Freeman</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>none</u>		17. INFORMANT <u>Wm. H. Murch, son 555 No. Clay, Kirkwood,</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>Cerebro vascular hemorrhage</u>										INTERVAL BETWEEN ONSET AND DEATH <u>NO</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>										<u>yr</u>	
DUE TO (c) <u>Arteriosclerotic heart disease with decompensation</u>										<u>NO</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4-200</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ Month _____ Day _____ Year _____ a. m. _____ 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			COUNTY		STATE	
21. I attended the deceased from <u>Dec. 1940</u> to <u>12-2-56</u> and last saw <sup>her</sup> <del>him</del> alive on <u>12-2-56</u> Death occurred at <u>2:30 P. m</u> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <u>Ellsworth C. Mestrop</u>					22b. ADDRESS <u>204 E. Big Bend</u>				22c. DATE SIGNED <u>12-5-56</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec 5, 1956</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>				
24. FUNERAL DIRECTOR <u>C. R. Lupton and Sons, 7233 Delmar,</u> ADDRESS _____					25. DATE RECD. BY LOCAL REG. <u>12-5-56</u>		26. REGISTRAR'S SIGNATURE <u>Hebeal R. Donker</u>				

(Licensed Embalmer's Statement on Reverse Side)

# 204 G. 1219 Jena 11/11/18  
1150: 1-0188.

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 *Clarence A. Mu...*

Licensed Embalmer No. 40

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.