

FILED JUN 14 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **18750**  
Registrar's No. **5234**

BIRTH NO.		REG. DIST. NO. <b>318</b>	PRIMARY REG. DIST. NO. <b>1003</b>	Registrar's No. <b>5234</b>
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death)		
b. CITY OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4354 Taft Ave</b>		e. STREET ADDRESS (If rural, give location) <b>2159 a 4354 Taft Ave</b>		
3. NAME OF DECEASED (Type or Print) <b>BMAA</b>		a. (First) <b>MAE</b>	b. (Middle) <b>HANDLER</b>	c. (Last) <b>HANDLER</b>
4. DATE OF DEATH <b>6-3-1957</b>		5. SEX <b>Female</b>		
6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>12-1-1877</b>
9. AGE (in years last birthday) <b>78</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 1 HR. Hours <b>0</b> Min. <b>0</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>Illinois</b>
13a. FATHER'S NAME <b>John Williams</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Jenkins</b>		14. NAME OF HUSBAND OR WIFE <b>Albert P. Handler</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Albert P. Handler</b> ADDRESS <b>4354 Taft Ave</b>
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic myocarditis</b> ANTECEDENT CAUSES <b>Senility</b> DUE TO (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>Senility -</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <b>2</b> YES <input type="checkbox"/> NO <input checked="" 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)		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 <b>5-27-57</b> <b>1946</b> , 19 <b>June 3</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 27</b> , 19 <b>57</b> , and that death occurred at <b>5:15 A.M.</b> , from the causes and on the date stated above.				
23a. SIGNATURE <b>D. Benjamin</b>		23b. ADDRESS <b>7430 Virginia M.D.</b>		23c. DATE SIGNED <b>6/3/57</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>6-5-1957</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>
24d. LOCATION (City, town, or county) (State) <b>10160 Gravois Road Mo.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Biegenstein Bros</b> ADDRESS <b>6409 Gravois Ave</b>		
DATE REC'D BY LOCAL REG. <b>JUN 4 57</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b>		

Dr. Benjamin 7430 Virginia Ave  
 1:30 to 4:30  
 MAKE A PERMANENT RECORD  
 WRITE PLAINLY—USING UNFADING BLACK INK—

STATE OF ILLINOIS  
DEPARTMENT OF HEALTH

ILLINOIS

DEPARTMENT OF HEALTH

CERTIFICATE

1911-1-1

ILLINOIS

DEPT

HEALTH

1911

1-1-1911

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HEALTH

ILLINOIS

1911

1-1-1911

ILLINOIS

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

1911-1-1

DEPT

HEALTH

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 *Lawrence S. Seymour*

Licensed Embalmer No. *434*

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.

1911-1-1