

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

47606

STATE FILE NUMBER
12311

FILED JAN 27 1958

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

S. 300
1557
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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN University City	
c. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital		d. STREET ADDRESS 7349a, Lindell Blv	
3. NAME OF DECEASED (Type or print) MABEL		4. DATE OF DEATH Dec. 21st 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 5 - 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ST. LOUIS MISSOURI
13a. FATHER'S NAME SAMUEL J. MARKS		13b. MOTHER'S MAIDEN NAME Ida Mark FLINT	14. NAME OF HUSBAND OR WIFE None
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 Mrs. Annie Knaup, 7469 Hoover Avenue
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>Cerebral System Degeneration of Special Cord sleep</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) "			INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
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.) <u>2901</u>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		20d. INJURY OCCURRED WHILE AT <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>December 1956</u> , to <u>12-21-57</u> and last saw her alive on <u>12-20-57</u> Death occurred at <u>102:</u> _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title) M.D.		22b. ADDRESS <u>35 N. Central, Clayton 5-40</u>	
22c. DATE SIGNED <u>12-21-57</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	
23b. DATE <u>12/24/57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>	
23d. LOCATION (City, town, or county) <u>St. Louis County, Missouri</u>		24. FUNERAL DIRECTOR <u>C. R. Lupton & Sons, 7233 Delmar</u>	
25. DATE RECD. BY LOCAL REG. <u>DEC 23 57</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

will provide copy

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 L. Murray*

Licensed Embalmer No. *4017*

P. O. Address *St. Louis Mo*

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.