RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS AUG 26 1959

59-030985

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 2253

DED

1. PLACE OF DEATH
a. COUNTY: St.Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kirkwood — Length of stay in 1b: 15-mon.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Ozark Nursing Home — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY:
c. CITY OR TOWN: St.Louis — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 339 North Taylor Ave. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth Middle: V. Last: Soper

4. DATE OF DEATH: Month: August Day: 19 Year: 1959

5. SEX: F.
6. COLOR OR RACE: W.
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 2/14/1880
9. AGE (last birthday): 79
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HR: Hours: Min.:

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): St.Louis,Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.

13a. FATHER'S NAME: Matthew P.Brazill
13b. MOTHER'S MAIDEN NAME: Ellen Beahan
14. NAME OF HUSBAND OR WIFE: William A.Soper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Address: Mrs.H.P.McCarthy,5896 Cabanne Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days!
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral arteriosclerosis — ?
DUE TO (c) Generalized arteriosclerosis — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 7/21/58 to 8/19/59 and last saw her alive on 8/19/59
Death occurred at 11:48 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: F. W. Brunt M.D. (Degree or title)
22b. ADDRESS: 5926 Manchester St. Louis 6, Mo.
22c. DATE SIGNED: 8/19/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Aug.21,1959
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St.Louis,Missouri

24. FUNERAL DIRECTOR: Arthur J. Donnelly ADDRESS: 3840 Lindell Blvd.
25. DATE RECD. BY LOCAL REG.: 8-20-59
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Wm S. Saifert

Licensed Embalmer No. 4699

P. O. Address 3840 Lundsly

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