

LED MAY 4-1961 AMENDED
 District No. **318** Primary Registration District No. **1003** Registrar's No. **3980** STATE FILE NUMBER **15053**

DATE AMENDED

INSTEAD OF DOCUMENT

ITEM NO. SHOULD READ BY AFFIDAVIT OF

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|---|---|------------------------------------|--|--|------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 2-days | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 7701 Vermont Ave. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Hazel Middle Louise Last Daniels | | | | 4. DATE OF DEATH Month April Day 25 Year 1961 | | | | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 8/1/08 | | 9. AGE (last birthday) 52 | | 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) Glider Worker | | | | 10b. KIND OF BUSINESS OR INDUSTRY Robertson Aircraft | | | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | |
| 13a. FATHER'S NAME Walter Senn | | | | 13b. MOTHER'S MAIDEN NAME Veronica Wolfe | | | | 14. NAME OF HUSBAND OR WIFE Edward Daniels | | | | | |
| 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. unknown | | 17. INFORMANT Address Edward Daniels - 7701 Vermont Ave. | | | | | | | |
| 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 Apoplexy DUE TO (b) Hypertensive Heart Disease DUE TO (c) Chronic Nephritis 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) 592x | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day 2 yrs 2 yrs | | | |
| 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.) 592x | | | | | | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | | | | | | | | | | | | | |
| 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 Jan. 1961 to Apr 25-61 and last saw her live on Apr. 25-61 Death occurred at 5:30 P. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22. SIGNATURE (Degree or title) George A. O'Sullivan, M.D. | | | | | | 22b. ADDRESS 7629 Ivory Ave | | | 22c. DATE SIGNED 4-26-61 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE Apr. 28, 1961 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery | | | 23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS WACKER-HELDERLE-3634 Gravois Ave. | | | | 25. DATE RECD. BY LOCAL REG. APR 26 1961 | | 26. REGISTRAR'S SIGNATURE Karl Smith M.D. | | | | | | | |

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 M. Bello

Licensed Embalmer No. 4375

P. O. Address St. Louis 23 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.