

No. 300
10-48

FILED APR 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10403

State File No. 2693

318

1003

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>St. Louis Mo</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis</u>		c. LENGTH OF STAY (In this place) <u>0</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>MO</u> OR TOWN <u>17</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Deaconess Hosp</u>				d. STREET ADDRESS <u>4061 Humphrey</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u>		b. (Middle) <u>A.</u>		c. (Last) <u>Messing</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3-23-1949</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>April 13 1870</u>	
9. AGE (In years last birthday) <u>78</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>10</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
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 _____		11. BIRTHPLACE (State or foreign country) <u>St. Louis Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>M. Farrington</u>			13b. MOTHER'S MAIDEN NAME <u>Bridget Gill</u>			14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mae E. Scally</u>		ADDRESS <u>4061 Humphrey</u>	
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, asthma, etc. It means the disease, injury, or complication which caused death.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Medical Certification</u> <u>Fracture of pericranial</u> <u>Diabetic</u> <u>180</u> <u>Circulatory failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>(Eight)</u>	
		2. ANTECEDENT CAUSES Mention conditions, if any, which may have contributed to the death but not stated in (a) or (b) or (c) causing death. <u>180</u>					
		3. OTHER SIGNIFICANT CONDITIONS Mention conditions contributing to the death but not stated in (a) or (b) or (c) causing death. <u>180</u>					
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>city - MO</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>March 19 1949 2</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>fell getting up at night</u>			
22. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____ that I last saw the deceased alive on _____, 19____ and that death occurred at <u>4:00 PM.</u> from the causes and on the date stated above.							
23a. SIGNATURE (Date or Title) <u>Judith J. Jones MD</u>				23b. ADDRESS <u>3720 Wadsworth</u>		23c. DATE SIGNED <u>March 4</u>	
24a. BURIAL, CREMATION, REBURY (Specify) <u>Burial</u>		24b. DATE <u>3-26-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis MO</u>	
DATE REC'D BY LOCAL REG. <u>MAR 25 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Lasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wingbermuehle Funeral H.</u>		ADDRESS <u>3819 S G S. Grand VI</u>	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

working under my personal supervision.

Student
Student Embalmer

Student Embalmer No.

Signed

Tom H. Sweeney

Licensed Embalmer No. *4343*

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 this body is not embalmed, fact should be so stated above.