

FILED SEP 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28656

State File No.

BIRTH NO.

REG. DIST. NO. 318PRIMARY REG. DIST. NO. 1003Registrar's No. 7620

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY 1700 17 9	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If rural, give location) 10 3920 Sullivan Ave.	
3. NAME OF DECEASED (Type or Print) Elizabeth M. Wall		4. DATE OF DEATH (Month) (Day) (Year) Sept. 1, 1949	
5. SEX F. /	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S. /	8. DATE OF BIRTH May 30, 1881
9. AGE (In years last birthday) 68		10. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Nicholas Wall		13b. MOTHER'S MAIDEN NAME Mary McDonnell	
14. NAME OF HUSBAND OR WIFE		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.		17. INFORMANT'S SIGNATURE OR NAME Miss Catherine B. Wall, 3920 Sullivan Ave.	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary arteriosclerosis</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 94	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 4201		22. I hereby certify that I attended the deceased from Aug 31, 1949 to Sept 4, 1949, that I last saw the deceased alive on Sept 1, 1949, and that death occurred at 3 P. M., from the causes and on the date stated above.	
23a. SIGNATURE J. B. Laster		23b. ADDRESS 634 W. Grand	
23c. DATE SIGNED 9/1/49		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE Sep 5, 1949		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE J. B. Laster	
25. FUNERAL DIRECTOR'S ADDRESS 3840 Lindell Blvd.		DATE REC'D BY LOCAL REG. SEP 2 1949	

(Licensed Embalmer's Statement on Reverse Side)

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

300
48

med 7-1

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
Student Embalmer

Signed _____

W.H. Vanmatre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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