

FILED MAR 4 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6787

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1728**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Illinois</b> b. COUNTY <b>Fayette</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>ST. LOUIS</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Brownstown</b>	
c. LENGTH OF STAY (In this place) <b>26 days</b>		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Barnes Hospital,</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>LYDA</b>	b. (Middle) <b>LOUISE</b>	c. (Last) <b>STORM</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>FEB. 21, 1950</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 29, 1917</b>	9. AGE (In years last birthday) <b>33</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Fayette Co., Ill.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
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13a. FATHER'S NAME <b>Edward Arnold</b>	13b. MOTHER'S MAIDEN NAME <b>Maude Williams</b>	14. NAME OF HUSBAND OR WIFE <b>Arthur Storm</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Arthur Storm, Brownstown, Ill.</b>	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Atelectasis</b>		<b>4 hrs</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) <b>Postnal vein &amp; sup. mesenteric vein thrombosis</b> DUE TO (c) <b>Lower nephron nephrosis</b>		<b>10 days</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Lower nephron nephrosis</b>		<b>9 days</b>	

19a. DATE OF OPERATION <b>1-26-50</b>	19b. MAJOR FINDINGS OF OPERATION <b>Bangorous bowel due to volvulus</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) <b>5703</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <b>2:00 p.m.</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **1-26-50**, 19\_\_\_, to **2-21-50**, 19\_\_\_, that I last saw the deceased alive on **2-21-50**, 19\_\_\_, and that death occurred at **5:05p** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Frank B. Norbury M.D.</b>	23b. ADDRESS <b>Barnes Hospital</b>	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>2-22-50</b>	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) <b>Fayette Co., Ill.</b>
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DATE REC'D BY LOCAL REG. <b>FEB 22 1950</b>	REGISTRAR'S SIGNATURE <b>Albert H. Hoppe</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b>	ADDRESS <b>4700 Washington Blvd.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAR 6 1950

**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 \_\_\_\_\_

Licensed Embalmer No. 3657

P. O. Address \_\_\_\_\_

**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.**