

FILED FEB 17 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7227

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>6076</u> Registrar's No <u>265</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give town or town Koch (rural))		c. LENGTH OF STAY (in this place) <u>248 days</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		10 <u>10</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>			d. STREET ADDRESS (If rural, give location) <u>3968 Ashland</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u>		b. (Middle) <u>Bernice</u>	c. (Last) <u>Wren</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>1-30-50</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10-19-17</u>	9. AGE (in years last birthday) <u>32</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	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>Charles Scott</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Broderick</u>		14. NAME OF HUSBAND OR WIFE <u>Gerald Wren</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>497-09-5587</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Hospital Records, Robt. Koch Hosp.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Tuberculous Meningitis</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Tuberculosis of Spines</u> DUE TO (c) <u>Pulmonary Tuberculosis</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>(??)</u> <u>1 1/2 yrs.</u> <u>(??)</u> <u>7 yrs (?)</u> <u>002X</u>
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>Tuberculosis of Spine</u>			20. AUTOPSY? YES <input checked="" 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) _____		21f. HOW DID INJURY OCCUR? _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22. I hereby certify that I attended the deceased from <u>5-27-49</u> , 19 <u>49</u> , to <u>1-30-50</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>1-30-50</u> , and that death occurred at <u>11:40 P.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>William A. Turner MD</u> (Degree or title)		23b. ADDRESS <u>Robert Koch Hospital</u>		23c. DATE SIGNED <u>1-31-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>2/3/50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>1-31-50</u>	REGISTRAR'S SIGNATURE <u>Robert Koch Hospital</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Sullivan Funeral Dir. 2849 Euclid</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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Robert L. Binkman*

Licensed Embalmer No. 3553

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.