

FILED JUN 9 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 18515  
4950

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

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, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2079	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5443 Geraldine Ave.		d. STREET ADDRESS (If rural, give location) 5443 Geraldine Ave. 0	
3. NAME OF DECEASED (Type or Print) Johanna		4. DATE OF DEATH (Month) (Day) (Year) June 2, 1950.	
5. SEX female		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	
6. COLOR OR RACE white		8. DATE OF BIRTH February 27, 1879	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Dennis O'Leary		13b. MOTHER'S MAIDEN NAME unknown		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. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Johanna Vollman 5443 Geraldine 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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH None
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic valvular heart disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis		
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 checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <i>ad</i>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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? H. 500	

22. I hereby certify that I attended the deceased from date 15, 1949 to June 2, 1950, that I last saw the deceased alive on June 2, 1950, and that death occurred at 10:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) D. P. Mennon M.D.		23b. ADDRESS 5330 Geraldine Ave.		23c. DATE SIGNED 6/5/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6-6-50.		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri.			

DATE REC'D BY LOCAL REG. JUN 5 1950		REGISTRAR'S SIGNATURE Dr. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Math Hermann & Son, Inc. 2161 E. Fair Ave.	
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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.

Signed.....  
Student Embalmer

Signed

Student Embalmer No. ....

Licensed Embalmer No. 3737

P. O. Address St. Louis, Missouri

**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.