

FILED NOV 24 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38387

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>9665</b>	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>				c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>			
c. LENGTH OF STAY (in this place)				d. STREET ADDRESS (If rural, give location) <b>5237 ROBIN AVE.</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ISOLATION HOSPITAL</b>				7			
3. NAME OF DECEASED a. (First) <b>Geraldine</b>			b. (Middle)		c. (Last) <b>Curry</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 13 1950</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <b>Never Married</b>		8. DATE OF BIRTH <b>July 16 1932</b>		9. AGE (In years last birthday) <b>18</b>	10. IF UNDER 1 YEAR Month   Day   Hours   Min. <b>3   27</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>St. Louis Mo.</b>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <b>John Curry</b>			13b. MOTHER'S MAIDEN NAME <b>Irene Wilcox</b>		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>John Curry 5237 Robin Ave.</b>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary Oedema</b>				INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Septicemia</b>				<b>24 hrs.</b>	
		DUE TO (c) <b>Measles</b>				<b>3 Days</b>	
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)		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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>0831</b>			
22. I hereby certify that I attended the deceased from <b>Nov. 10, 1950</b> , to <b>Nov. 13, 1950</b> , that I last saw the deceased alive on <b>Nov. 12, 1950</b> , and that death occurred at <b>9:30 A.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Robert M. Egan</b>				23b. ADDRESS <b>M. D. 4356 Warne Avenue (7)</b>		23c. DATE SIGNED <b>11-14-50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>11/16/50</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>		
DATE RECEIVED BY LOCAL HEALTH DEPT.		REGISTRAR'S SIGNATURE <b>J. B. Fasano</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Sullivan Funeral Dir. 2849 N. Euclid</b>			

(Licensed Embalmer's Statement on Reverse Side)

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. Brinkman*

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.