

FILED NOV 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38407

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9239**

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 Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 5-27-47 to 10-29-50		2089	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Infirmiry Hospital		8. STREET ADDRESS (If rural, give location) 8945 Newby St.,	

3. NAME OF DECEASED (Type or Print) a. (First) Mathilda b. (Middle) c. (Last) Deul			4. DATE OF DEATH (Month) (Day) (Year) 10 29 50		
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	
8. DATE OF BIRTH May 29th, 1867		9. AGE (In years last birthday) 83		10. CITIZEN OF WHAT COUNTRY? St. Louis	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis	

13a. FATHER'S NAME Fred Rabenneck		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Louis Deul	
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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) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Florence Burrows, 8945 Newby St.,	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease		DUPLICATE TO (b) Generalized Arteriosclerosis				
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUPLICATE 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"/>	
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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)	
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? 42nd	

22. I hereby certify that I attended the deceased from _____, 19____, to **10/29**, 19**50**, that I last saw the deceased alive on **10/29**, 19**50** and that death occurred at **10:55m. PM** from the causes and on the date stated above.

22a. SIGNATURE Palmer Truman Bowlich M D		22b. ADDRESS		22c. DATE SIGNED	
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 11/1/50		24c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
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DATE REC'D BY LOCAL REG. Oct 31 1950		REGISTRAR'S SIGNATURE J. B. Lesater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Diedrich F. Home, 8319 Hallsferry	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 *J. W. Beasley* Student Embalmer No.....
Licensed Embalmer No. *3653*

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.