

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24243**
Registrar's No. **6887**

FILED AUG 15 1951

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **100a**

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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Missouri		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	
c. LENGTH OF STAY (In this place) 8 yrs		d. STREET ADDRESS (If rural, give location) 5351 Delmar	
d. FULL NAME OF HOSPITAL OR INSTITUTION Masonic Hospital			

3. NAME OF DECEASED a. (First) Maye		b. (Middle) _____		c. (Last) Ary		4. DATE OF DEATH (Month) 8- (Day) 1- (Year) 1951		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W		8. DATE OF BIRTH May-2-1866		9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months 3 Days _____	IF UNDER 12 HRS. Hours _____ Min. _____
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) Anamosa, Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.		

13a. FATHER'S NAME Nelson Potter		13b. MOTHER'S MAIDEN NAME Acasha M. Hutchins		14. NAME OF HUSBAND OR WIFE W. H. Ary, deceased	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Louis Cholestan ADDRESS Supt.	
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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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocarditis				INTERVAL BETWEEN ONSET AND DEATH 6 days	
		ANTECEDENT CAUSES DUE TO (b) Chronic Interstitial Nephritis 6 years Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE 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? 592X	

22. I hereby certify that I attended the deceased from **10-7-**, 19 **44** to **8-1-**, 19 **51** that I last saw the deceased alive on **8-1-**, 1951, and that death occurred at **2 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Louis Cholestan (Degree or title) _____		23b. ADDRESS 508 N. Grand		23c. DATE SIGNED 8-1-51	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8-1-51		24c. NAME OF CEMETERY OR CREMATORY Rolla, Mo.		24d. LOCATION (City, town, or county) (State) _____	
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DATE RECD BY LOCAL AUG 1 1951		REGISTRAR'S SIGNATURE J B Lanter		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe ADDRESS 4700 Washington Blvd.	
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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.....

....., **Student Embalmer No.**

working under my personal supervision.

Student
Student Embalmer

Signed.....

Licensed Embalmer No.....

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.