

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24483
6737

State File No.
Registrar's No.

FILED AUG 7 1951

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) lwk.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2199
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital			e. STREET ADDRESS (If rural, give location) 4475 West Pine		
3. NAME OF DECEASED (Type or Print) a. (First) Lena		b. (Middle) _____	c. (Last) DeWitt	4. DATE OF DEATH (Month) (Day) (Year) July 27, 1951	
5. SEX F	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Widowed	8. DATE OF BIRTH Jan. 17, 1875	9. AGE (In years last birthday) 76	10. UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Little Rock, Ark.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Chas C. Burdell		13b. MOTHER'S MAIDEN NAME Mary Close		14. NAME OF HUSBAND OR WIFE Thomas M. DeWitt	
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 Gertrude Galloup		
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, asphyxia, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Thrombosis of Lenticulo - striate artery DUPLICATE TO (b) arterio sclerosis DUPLICATE TO (c) Hypertensive C-V. disease II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 6 days
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		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) _____		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? HH37			
22. I hereby certify that I attended the deceased from July 19, 1951 , to July 27, 1951 , that I last saw the deceased alive on 7-27, 1951 , and that death occurred at 11 A. m. , from the causes and on the date stated above.					
23a. SIGNATURE <i>[Signature]</i>		(Degree or title) _____	23b. ADDRESS 35 North Central, Clayton, Mo.		23c. DATE SIGNED 7-27-51
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE July 28, 1951	24c. NAME OF CEMETERY OR CREMATORY Rose Lawn Cemetery	24d. LOCATION (City, town, or county) (State) Little Rock Ark.		
DATE REC'D BY LOCAL REG. JUL 28 1951	REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		
			ADDRESS 6175 Delmar		

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

Dr Robt Zachy
35 N Central

4829

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.

Complete Post,
Student Embalmer No.

Signed *Joseph McCulloch*

Signed.....
Student Embalmer

Licensed Embalmer No. *2460*

P. O. Address *6145 Palmer*

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.