

FILED OCT 23 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 34899  
Registrar's No. 8702

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **100a**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS,</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS,</b>	
d. NAME OF HOSPITAL OR INSTITUTION <b>1502 E. GRAND</b>		e. STREET ADDRESS (If rural, give location) <b>1502 E. GRAND</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>CASSIE</b> b. (Middle) <b>L.</b> c. (Last) <b>CANOLE</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>OCT, 1, 1951</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>JAN, 23, 1888</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED SALESWOMEN</b>		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) if UNDER 1 YEAR Months Days if UNDER 4 WKS. Hours Min. <b>63</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED SALESWOMEN</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>INDIANA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN RYAN</b>	
13b. MOTHER'S MAIDEN NAME <b>CATHERINE GROGAN</b>		14. NAME OF HUSBAND OR WIFE <b>ROBERT L. CANOLE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>#</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>JOSEPHINE ( DODE) RYAN</b>		ADDRESS <b>1502 E. GRAND</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>Embryonic cardiac</b> ANTECEDENT CAUSES DUE TO (b) <b>chronic hypertension</b> DUE TO (c) <b>arteriosclerosis</b> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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>H20-1</b>			
22. I hereby certify that I attended the deceased from <b>Feb 1, 1951</b> , to <b>Oct 1, 1951</b> , that I last saw the deceased alive on <b>Oct 1, 1951</b> , and that death occurred at <b>7:30 P.M.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Ernest Rumboltz</b>		23b. ADDRESS <b>1418 East Rumboltz</b>	
23c. DATE SIGNED <b>Oct 2</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
24b. DATE <b>10/3/51</b>		24c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>	
24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MISSOURI</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Stroot - Carroll</b>	
DATE REC'D BY LOCAL REG. <b>OCT 2</b>		ADDRESS <b>4600 NATURAL BRIDGE</b>	

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.

Student Embalmer No.....

Signed..... *Albert Mayfield* .....

Signed.....  
Student Embalmer

Licensed Embalmer No. *3077*

P. O. Address *St. Louis Mo*

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.