

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35137

FILED OCT 23 1951

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8919**

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2069	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 5550 Powers	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hosp.			

3. NAME OF DECEASED (Type or Print) Ruth HEATON			4. DATE OF DEATH (Month) (Day) (Year) 10-8-1951		
a. (First)	b. (Middle)	c. (Last)			

5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED MARRIED	8. DATE OF BIRTH 11-5-1898	9. AGE (in years last birthday) 53	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 1 MIN. 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) St. Louis MO		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME HARRY Wood	13b. MOTHER'S MAIDEN NAME Rose Toy	14. NAME OF HUSBAND OR WIFE PAUL HEATON
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME PAUL HEATON		ADDRESS 5550 Powers	
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis	DUPLICATE			5 mo.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) Generalized arteriosclerosis			
	DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Chronic nephritis & secondary anemia.			

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" 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)
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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? H201
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22. I hereby certify that I attended the deceased from July, 1951, to 8 October, 1951, that I last saw the deceased alive on 8 October, 1951, and that death occurred at 7:15 P. m., from the causes and on the date stated above.

23a. SIGNATURE John F. McClann (Degree or title) M.D.	23b. ADDRESS St. John's Hospital	23c. DATE SIGNED 9 Oct 51
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24a. BURIAL, CREMATION, OR REMOVAL REMOVAL	24b. DATE 10-11-51	24c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO
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DATE REC'D BY LOCAL REG. OCT 9 1951	REGISTRAR'S SIGNATURE Paul Smith	25. FUNERAL DIRECTOR'S SIGNATURE SULLIVAN	ADDRESS 2849 E. 64th
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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 _____

Dustan Dieterle

Signed.....
Student Embalmer

Licensed Embalmer No. 4329

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.