

FILED NOV 24 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38625

State File No.

9784

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1002** Registrar's No.

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) TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) TOWN St. Louis 2119	
d. FULL NAME OF HOSPITAL OR INSTITUTION Spring & Easton Ave.		d. STREET ADDRESS (If rural, give location) 3711 Cass Ave. 0	
3. NAME OF DECEASED (Type or Print) a. (First) Lydia b. (Middle) E. c. (Last) Abshier		4. DATE OF DEATH (Month) (Day) (Year) Nov. 3, 1951	
5. SEX Female	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 30, 1887
9. AGE (In years last birthday) 63		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo. 0
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Edward Grooms	
13b. MOTHER'S MAIDEN NAME Maggie Finningan		14. NAME OF HUSBAND OR WIFE Charles A. Abshier	
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 Charles A. Abshier		ADDRESS 3711 Cass Ave.	
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* Subdural hemorrhage; Fracture of back legs, suffered when struck ANTECEDENT CAUSES Heart operated by one Dr. Foster (sic) at intersection of Spring and Easton Ave.; about 1235 am Nov 3 1951 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 no accident	
20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT (Specify) Accident	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Nov 3 5:12 a.m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 12:35 p.m. , from the causes and on the date stated above.		22. HOW DID INJURY OCCUR? 8/24 25	
23a. SIGNATURE (Degree or title) Patrick P. Ray, M.D.		23b. ADDRESS 1300 Clark	
23c. DATE SIGNED 11.5.51		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 11-6-1951		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly	
DATE REC'D BY LOCAL REG. NOV 5 1951		REGISTRAR'S SIGNATURE J. Carl Smith, M.D.	
25. FUNERAL DIRECTOR'S ADDRESS 3840		ADDRESS	

(Licensed Embalmer's Statement on Reverse Side)

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 me

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed



Licensed Embalmer No. 4699

P. O. Address St. Charles, Mo.

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.