

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 6288
1250

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				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, Mo		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2167			
d. FULL NAME OF HOSPITAL OR INSTITUTION 3860 UTAH				d. STREET ADDRESS (If rural, give location) 16 3860 UTAH			
3. NAME OF DECEASED (Type or Print) a. (First) MARGUERITE D. CAREY			b. (Middle) _____			c. (Last) _____	
4. DATE OF DEATH (Month) (Day) (Year) FEB. 9 1952							
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLED		8. DATE OF BIRTH DEC. 26, 1892	
9. AGE (In years last birthday) 59		10. UNDER 1 YEAR Months _____ Days _____		11. UNDER 1 HR. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOKKEEPER				10b. KIND OF BUSINESS OR INDUSTRY RICE-STIX DRY CO		11. BIRTHPLACE (State or foreign country) MISSOURI	
12. CITIZEN OF WHAT COUNTRY? U							
13a. FATHER'S NAME DANIEL J. CAREY			13b. MOTHER'S MAIDEN NAME MARGARET COLLINS			14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 489-07-2058		17. INFORMANT'S SIGNATURE OR NAME MRS. GRACE PESOLD ADDRESS 3860 UTAH			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)							
MEDICAL CERTIFICATION							
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage.				INTERVAL BETWEEN ONSET AND DEATH			
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.							
ANTECEDENT CAUSES							
Morbidity conditions, if any, giving rise to the above cause (a), stating the underlying cause last.							
DUE TO (b) Arteriosclerosis				Not			
DUE TO (c) uncertain				Known			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None							
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? 331X			
22. I hereby certify that I attended the deceased from 6/9/50 , 19____, to 2/3/52 , 19____, that I last saw the deceased alive on 2/4/52 , 19____, and that death occurred at 8:00 A.M. , from the causes and on the date stated above.							
23a. SIGNATURE Lawrence Schlenker, M.D.				23b. ADDRESS 3515 South Grand St. Lmo 18		23c. DATE SIGNED 2/8/52	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE FEB. 9 1952		24c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM.		24d. LOCATION (City, town, or county) (State) ST. LOUIS Mo	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE FEB 8 1952		REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutie 2906 GRAYOIS			

(Licensed Embalmer's Statement on Reverse Side)

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

