

FILED MAR 24 1952

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

9632

318

1003

2128

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_ 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 town OR TOWN St. Louis	c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township OR TOWN St. Louis	2099
d. FULL NAME OF HOSPITAL OR INSTITUTION 5206 Conde Str.		d. STREET ADDRESS (If rural, give location) 9 <del>5206 Conde Str</del> 5206 Conde St	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) EELIPA	b. (Middle) XXXX	c. (Last) ARTEAGA	Mar.	5.	1952

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 26 1876	9. AGE (In years last birthday) 75	10. MONTHS 5	11. YEAR 5	12. HOURS 5	13. MIN. 5
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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) Barcelona Spain		12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME Unknown Gonzales		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Robert Arteaga	
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Robert F. Arteaga		ADDRESS 2025 Adelaide	
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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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: <i>Cerebral Haemorrhage</i>  ANTECEDENT CAUSES: <i>Arterio-Sclerosis</i> DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH 2-19-52  2	
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input 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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 331X	
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22. I hereby certify that I attended the deceased from 2-19, 1952, to 3-5, 1952, that I last saw the deceased alive on 2-5, 1952, and that death occurred at 3:15 P.M., from the causes and on the date stated above.

23a. SIGNATURE <i>E. E. Farley</i>	FARLEY (Print name or title)	23b. ADDRESS 680 Sullivan Road	23c. DATE SIGNED 3-5-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Mar 7, 52	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. MAR 5 1952	REGISTRAR'S SIGNATURE <i>Carl Smith</i>	25. FUNERAL DIRECTOR'S SIGNATURE W. A. Stock, 2117 E. Grand Blvd.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

6623 Lillian

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Frank A. Moore

Licensed Embalmer No. 3041

P. O. Address 2117 E. Grand

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.