

FILED JUN 16 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18014

State File No. 4937

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) St. Louis,		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2229	
c. LENGTH OF STAY (in this place) 4 yrs. 9 mos. 4 days.		d. STREET ADDRESS (If rural, give location) 1304 Missouri 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address and location) City Infirmery Hospital 21			

3. NAME OF DECEASED (Type or Print) ELIZABETH	a. (First)	b. (Middle)	c. (Last) GEAIR	4. DATE OF DEATH (Month) (Day) (Year) 5 26 1952
---	------------	-------------	-----------------	---

5. SEX Female/	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH July 27 1865	9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ad. Nurse		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri D		12. CITIZEN OF WHAT COUNTRY? U.S.		

13a. FATHER'S NAME Albert Geair	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Anna none
---------------------------------	-----------------------------------	---------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME ADDRESS City Infirmery- 5800 Arsenal St. 5800
--	----------------------------	---

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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5+ years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atherosclerotic Heart Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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.			

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) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4200

22. I hereby certify that I attended the deceased from 8/19 1947, to May 26 1952, that I last saw the deceased alive on May 26 1952, and that death occurred at 11:40 P.M., from the causes and on the date stated above.

23a. SIGNATURE George M. Tanaka, M.D.	(Degree or title)	23b. ADDRESS 5600 Arsenal St.	23c. DATE SIGNED 5/27/1952
---------------------------------------	-------------------	-------------------------------	----------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5-31-52	24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cem	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
--	-------------------	--	---

DATE REC'D BY LOCAL REG. MAY 29 1952	REGISTRAR'S SIGNATURE J. Carl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Witt Bros & Co 2929 S. Jefferson
--------------------------------------	---	---

(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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *D. M. Davis*

Licensed Embalmer No. *9241*

P. O. Address *2229 Jefferson*

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.