

No. 300  
10-48

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21946

State File No. \_\_\_\_\_

JUL 9 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5949**

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

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY _____	
b. CITY OR TOWN <b>St Louis Mo.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St Louis 2059</b>	
c. LENGTH OF STAY (in this place) <b>19 days</b>		d. STREET ADDRESS (If rural, give location) <b>6204 Suburban Ave</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Barnard Fr Skinfca</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Rosia</b> b. (Middle) <b>Belle</b> c. (Last) <b>Dwyer</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>June 24 1952</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	
8. DATE OF BIRTH <b>9-3-1899</b>		9. AGE (In years last birthday) <b>72</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>St. Charles Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	

13a. FATHER'S NAME <b>Michael Hausman</b>		13b. MOTHER'S MAIDEN NAME <b>Annie F Baldridge</b>		14. NAME OF HUSBAND <b>John L Dwyer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Hospital Record</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>	

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Thrombosis</b>		II. OTHER SIGNIFICANT CONDITIONS <b>Melanoma w/ metastases</b>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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? <b>4201</b>		22. I hereby certify that I attended the deceased from <b>6 June, 1952, to 24 June, 1952</b> , that I last saw the deceased alive on <b>23 June 1952</b> , and that death occurred at <b>7:00 AM.</b> , from the causes and on the date stated above.			

23. SIGNATURE <b>Joseph P. Doyle M.D.</b> (Degree or title)		23b. ADDRESS <b>Barnard HOSPITAL ST. LOUIS, MO.</b>		23c. DATE SIGNED <b>24 JUNE 52</b>	
24a. BURIAL (CREMATION, REMOVAL) (Specify) <b>Removal</b>		24b. DATE <b>June 27 52</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cem</b>	
24d. LOCATION (City, town, or county) (State) <b>St. Charles Mo.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Jos. W. Clark</b> ADDRESS <b>1125 Hodiamont Ave.</b>			

DATE REC'D BY LOCAL REG. **JUN 25 1952** REGISTRAR'S SIGNATURE \_\_\_\_\_

(Licensed Embalmer's Statement on Reverse Side)

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.....  
Student Embalmer

Signed.....

Licensed Embalmer No. 2663

P. O. Address 1125 Hiram

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.