

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 3 1953

State File No. 3852

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No. 0652

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) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. Louis 2079	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony Hospital		d. STREET ADDRESS (If rural, give location) 4316 ⁰ ST. Mihiel Court	
3. NAME OF DECEASED (Type or Print) a. (First) Andrea b. (Middle) J c. (Last) Truex		4. DATE OF DEATH (Month) (Day) (Year) I 19 1953	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED Never married	8. DATE OF BIRTH I - I - 1946
9. AGE (In years last birthday) 7		10. MONTHS 0	11. DAYS 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Torquay England 4		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME Walter T Truex		13b. MOTHER'S MAIDEN NAME Geraldine Boden	
14. NAME OF HUSBAND OR WIFE None			
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 Walter J Truex		ADDRESS 4316 St. Mihiel CT.	
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* (a) <u>Brain Tumor of Brain + Spinal Cord</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>None</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Increased Intracranial Pressure</u>	
19a. DATE OF OPERATION 1-18-53		19b. MAJOR FINDINGS OF OPERATION <u>Marked Swelling of Brain - Tumor proved post mortem</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 231X			
22. I hereby certify that I attended the deceased from <u>1-14, 1953</u> , to <u>1-19, 1953</u> , that I last saw the deceased alive on <u>1-19, 1953</u> , and that death occurred at <u>8:20 AM</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Frank A. Palazzolo MD</u>		23b. ADDRESS <u>4161 Lindell</u>	
23c. DATE SIGNED <u>1-20-53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24b. DATE I - 21 - 1953	
24c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
DATE REC'D BY LOCAL REG. JAN 20 1953		REGISTRAR'S SIGNATURE <u>Carl Smith</u>	
25. GENERAL DIRECTOR'S SIGNATURE <u>W. Bopp</u>		ADDRESS <u>St. Louis</u>	

(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.....

working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed Felix Durand

Licensed Embalmer No. 3034

P. O. Address 1 Greshamwood

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.