

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **16576**

FILED APR 29 1953

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **590** Registrar's No. **1074**

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

1. PLACE OF DEATH a. COUNTY St. Louis,		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Valley Park,		c. LENGTH OF STAY (in this place) 5 Years	
d. FULL NAME OF HOSPITAL OR INSTITUTION Route 2 Box 342		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Valley Park 476 J	
3. NAME OF DECEASED (Type or Print) a. (First) Mathilda b. (Middle) P. c. (Last) Slavens		4. DATE OF DEATH (Month) (Day) (Year) April 13, 1953.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 17, 1891
9. AGE (In years last birthday) 62		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	10b. KIND OF BUSINESS OR INDUSTRY Housewife
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME William Saville		13b. MOTHER'S MAIDEN NAME Barbara Geobel	
14. NAME OF HUSBAND OR WIFE Aubrey E. Slavens		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 AND ADDRESS Aubrey E. Slavens, Route 2, Box 342, Valley Park, Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage ANTECEDENT CAUSES DUE TO (b) Hypertensive heart disease DUE TO (c) Myocarditis, chronic II. OTHER SIGNIFICANT CONDITIONS Bronchial asthma <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>	
19a. DATE OF OPERATION 7/1		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		443X	
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 (Month) (Day) (Year) (Hour) OF INJURY	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 1946 , to 4-13 1953 , that I last saw the deceased alive on 4-13 1953 , and that death occurred at 3:45 P.m. , from the causes and on the date stated above.			
23a. SIGNATURE H. R. ... (Degree or title)		23b. ADDRESS Box 91 Fenton, Mo	
23c. DATE SIGNED 4-14-53		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE Apr. 16, 1953.		24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	
24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Gebken-Benz Mortuary 2842 Meramec St.	
DATE REC'D BY LOCAL REG. 4-14-53		REGISTRAR'S SIGNATURE H. R. ...	

(Licensed Embalmer's Statement on Reverse Side)

St. Louis, 18, Mo.

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 ME

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Laron C. Percy

Licensed Embalmer No. 4094

2842 Meramec St.

P. O. Address St. Louis, 18, Missouri.

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.