

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19707

FILED JUN 7 - 1953

State File No. ....

BIRTH NO. .... REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4908**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>St. Louis, Missouri</b> ) OR TOWN <b>St. Louis, Missouri</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>2239 2420 MENARD</b>	

3. NAME OF DECEASED (Type or Print) <b>WALTER</b>	a. (First)	b. (Middle)	c. (Last) <b>0 MONTAGUE</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>MAY 14, 1953</b>
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>DIVORCED 3</b>	8. DATE OF BIRTH <b>APRIL 3 1874</b>	9. AGE (In years last birthday) <b>79</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 WRS. Hours	IF UNDER 1 WRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ATTENDANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARINE Hosp.</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U</b>		

13a. FATHER'S NAME <b>— MONTAGUE</b>	13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	14. NAME OF HUSBAND OR WIFE
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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)	16. SOCIAL SECURITY NO. <b>494-09-7704</b>	17. INFORMANT'S SIGNATURE OR NAME <b>HELEN HAGIS</b>	ADDRESS <b>3174 S. COMPTON</b>
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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>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Arterio Sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</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) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Malnutrition</b>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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? <b>334X</b>
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22. I hereby certify that I attended the deceased from **3-31-53**, 19\_\_\_, to **5-14-53**, 19\_\_\_, that I last saw the deceased alive on **5-14-53**, 19\_\_\_, and that death occurred at **11:30A.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Charles Burnside M.D.</b>	23b. ADDRESS <b>1515 Lafayette Avenue</b>	23c. DATE SIGNED <b>5-14-53</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>MAY 16 1953</b>	24c. NAME OF CEMETERY OR CREMATORY <b>ST. MATTHEW CEM</b>	24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS Mo</b>
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DATE REC'D BY LOCAL REG. <b>MAY 15 1953</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas Kutis</b>	ADDRESS <b>2906 Graves</b>
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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.....  
Signature of Student Embalmer

Signed..... *Samuel C. Hill*

Licensed Embalmer No. *43470*

P. O. Address *2906*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.