

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

37437

State File No.

FILED OCT 30 1953

BIRTH NO.

REG. DIST. NO.

318

PRIMARY REG. DIST. NO.

1003

Registrar's No.

10164

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Louis, Missouri</u>)		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN <u>ST. LOUIS</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis City Hospital</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>JOSEPHINE</u>		b. (Middle) <u>A.</u>	
		c. (Last) <u>MISSERE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>OCTOBER 24, 1953</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	
8. DATE OF BIRTH <u>MAR 29 1887</u>		9. AGE (In years last birthday) <u>66</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WORKER</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>CHARLES MISSERE</u>	
14. NAME OF HUSBAND OR WIFE		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. <u>488-10-9904</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>MARY BREEN 2026 MENARD</u>		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, asphyxia, etc. It means the disease, injury, or complication which caused death.		19. DATE OF OPERATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Stroke Adams Syndrome</u>		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		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? <u>4200</u>	
22. I hereby certify that I attended the deceased from <u>10-1-53</u> , 19 <u> </u> , to <u>10-24-53</u> , 19 <u> </u> , that I last saw the deceased alive on <u>10-24-53</u> , 19 <u> </u> , and that death occurred at <u>3:25A</u> m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>Phillip Corino MD</u>		23b. ADDRESS <u>1515 Lafayette Avenue</u>		23c. DATE SIGNED <u>10-24-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>OCT 27 1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>S. S. PETER & PAUL</u>	
24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>		DATE REC'D BY LOCAL REG. <u>OCT 26 1953</u>		REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas Kuts</u>		ADDRESS <u>2906 Grand</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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Leo J. Budd*
Licensed Embalmer No. *398*
P. O. Address *St. Louis*

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.