

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6155**
Registrar's No. **1816**

BIRTH NO. FILED **MAR 8 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY			
b. CITY OR TOWN ST. LOUIS, MISSOURI		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or Print) SUSIE		a. (First) B.		c. (Last) FEIN	
5. SEX Female		6. COLOR OR RACE White		4. DATE OF DEATH (Month) (Day) (Year) FEBRUARY 24, 1954	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced		8. DATE OF BIRTH Oct. 22nd. 1892		9. AGE (In years last birthday) 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Private family		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
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. 499-12-9114	
17. INFORMANT'S SIGNATURE OR NAME Jack Fein		ADDRESS Above			
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* Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 443X	
22. I hereby certify that I attended the deceased from 2-19-54 , 19___, to 2-24-54 , 19___, that I last saw the deceased alive on 2-24-54 , 19___, and that death occurred at 12:40 P.m. , from the causes and on the date stated above.					
23a. SIGNATURE Robert J. Healey M.D.		(Degree or title)		23b. ADDRESS 1515 Lafayette Avenue	
23c. DATE SIGNED 2-24-54		24a. BURIAL, CREMATION, REMOVAL Removal		24b. DATE 2-28-54	
24c. NAME OF CEMETERY OR CREMATORY Resurrection		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.			
DATE REC'D BY LOCAL REG. FEB 25 1954		REGISTRAR'S SIGNATURE J. Cash Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Jay B. Smith, Maplewood, Mo.	

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 *H E Burgess*

Licensed Embalmer No. *402*

P. O. Address *Maplewood*

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.