300
48

FILED MAY 17 1954

THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 17143

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4214

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2614A N. 22th. St.,

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
d. STREET ADDRESS (If rural, give location) 2614A N. 22th. St., 2209 20

3. NAME OF DECEASED (Type or Print) a. (First) AMNA b. (Middle) c. (Last) FORD

4. DATE OF DEATH (Month) (Day) (Year) May 10,1954

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH July 11,1870.
9. AGE (In years last birthday) 83 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) Peoria, Ill.
12. CITIZEN OF WHAT COUNTRY? U.S

13a. FATHER'S NAME Patrick Carroll
13b. MOTHER'S MAIDEN NAME Julia Shea
14. NAME OF HUSBAND OR WIFE Tom J. Ford Dec.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Tom O'day,5844a Macklind Ave.,

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH 10-15 yrs.

ANTECEDENT CAUSES
*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Generalized Infirmities — 10-15 yrs
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 ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 4500

22. *I hereby certify that I attended the deceased from* MAY 8, 1954, *to* MAY 10, 1954, *that I last saw the deceased alive on* MAY 10, 1954, *and that death occurred at* 6 a. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) S. J. Ciapciak M.D.
23b. ADDRESS 1901 Madison St.
23c. DATE SIGNED 5/10/54

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE May13,1954
24c. NAME OF CEMETERY OR CREMATORY Calvary Cem.,
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. MAY 11 1954
REGISTRAR'S SIGNATURE J Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Jos. W. Clark 1125 Hodiamont Ave.,

(Licensed Embalmer's Statement on Reverse Side)

## 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 .....
Student Embalmer

Signed Alfred J. Broedeker

Licensed Embalmer No. 2663

P. O. Address 1125 Hedemann

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.