

FILED JUL 2 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20941**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5749**

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

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis c. LENGTH OF STAY (in this place) 70 yrs d. FULL NAME OF HOSPITAL OR INSTITUTION Old Faith Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____ c. CITY OR TOWN St. Louis d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> e. STREET ADDRESS (If rural, give location) 4157 N. Prairie Ave. 210 1/2			
3. NAME OF DECEASED (Type or Print) a. (First) Cecelia b. (Middle) Marguerite c. (Last) Martin			4. DATE OF DEATH (Month) (Day) (Year) June 26, 1954.				
5. SEX Female		6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH July 14, 1877		
9. AGE (In years last birthday) (Months) (Days) (If under 1 year) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		11. BIRTHPLACE (City and State or Foreign Country) Brooklyn, New York			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY _____		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Jean Chevrelot		13b. MOTHER'S MAIDEN NAME Jennie Doriot		14. NAME OF HUSBAND OR WIFE Francis Martin			
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 ADDRESS Charles Wayne Martin-4157 N. Prairie Ave.			
MEDICAL CERTIFICATION							
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.							
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Post Sepsis Infection ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Left Side Cordis Pulvis DUE TO (c) Diabetic Mellitus et cetera				INTERVAL BETWEEN ONSET AND DEATH 10 days 10 days 10 days			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis generalis				3 to 5 yrs.			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input 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? 260x		
22. I hereby certify that I attended the deceased from <u>6/16</u>, 1954, to <u>6/26</u>, 1954, that I last saw the deceased alive on <u>6/26</u>, 1954, and that death occurred at <u>3:00 Am.</u>, from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) George W. Smith MD				23b. ADDRESS 4828 Natural Bridge Blvd.			
23c. DATE SIGNED 6/26/54		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6/28/54.			
24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.					
DATE REC'D BY LOCAL REG. JUN 28 1954		REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Calvin F. Fantz 4828 Natural Bridge Blvd.			

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 *John A. Mlinar*.....
Licensed Embalmer No. *4186*

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.