

FILED JUL 2 - 1954

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **21065**
Registrar's No. **5596**

318

PRIMARY REG. DIST. NO. **1003**

REG. DIST. NO. _____

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. 5596		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis <input type="checkbox"/>		c. LENGTH OF STAY (in this place) 14 Y 7M 20D		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"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CHRONIC HOSPITAL				e. STREET ADDRESS (If rural, give location) 13 5600 Arsenal St.				
3. NAME OF DECEASED (Type or Print) a. (First) MARY		b. (Middle) _____		c. (Last) ORTH		4. DATE OF DEATH (Month) 6 (Day) 22 (Year) 1954		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single <input checked="" type="checkbox"/>		8. DATE OF BIRTH unk 1874		
9. AGE (in years at birthday) 80		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HR. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and State or Foreign Country) Washington, Indiana		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 Single		
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 Hospital Records, 5600 Arsenal st. ADDRESS _____			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Artery Decline		ANTECEDENT CAUSES					years	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) Arterio Sclerosis					year	
		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 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) 4201 (STATE) _____				
21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from 11/2 , 19 39 , to 6/22 6/22 1954 ; that I last saw the deceased alive on June 22 , 19 54 , and that death occurred at 5:00A m., from the causes and on the date stated above.								
23a. SIGNATURE George Esker M.D. (Degree or title) <input checked="" type="checkbox"/>				23b. ADDRESS 5600 Arsenal St.		23c. DATE SIGNED 6/22/54		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 6-23-54		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) Washington, Ind.		
DATE REC'D BY LOCAL REG. JUN 23 1954		REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE POindexter F.H., Washington, Ind. ADDRESS _____				

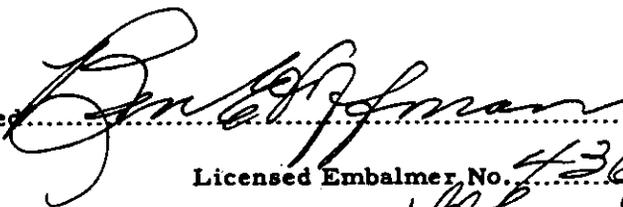
(Licensed Embalmer's Statement on Reverse Side)

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 .....
Licensed Embalmer No. 436

P. O. Address .....

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.