

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED AUG 2 - 1954

State File No. 24202

318

1003

Registrar's No. 6790

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. 24202	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city (incorporated town)? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Luke's Hospital				e. STREET ADDRESS (If rural, give location) 3 6565 Delor St. 2039			
3. NAME OF DECEASED (Type or Print) a. (First) JULIA		b. (Middle) V.		c. (Last) ALPISER		4. DATE OF DEATH (Month) (Day) (Year) July 21 1954	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 27, 1889		9. AGE (In years last birthday) 65	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) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME Thomas Mullin		13b. MOTHER'S MAIDEN NAME Mary O'Sullivan		14. NAME OF HUSBAND OR WIFE Marion G. Alpiser			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No None		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Marion G. Alpiser 6565 Delor St.			
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Internal Hemorrhage from ruptured spleenic artery suffered when deceased was crossed against door of garage by moving machine II. OTHER SIGNIFICANT CONDITIONS Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Conditions contributing to the death of not related to the disease or condition of the deceased garage at 6565 Delor Street about 500 pm July 19 1954 Accident				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT (Specify) SUCIDIAL MURDER Accidental		21b. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) Garage		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo. 830.17			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) July 19 54 5:00 pm		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 000 33			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 2:25A m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Patrick P. Taylor Coroner				23b. ADDRESS 1300 Clark		23c. DATE SIGNED 7.22.54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		24b. DATE July 24, 1954		24c. NAME OF CEMETERY OR CREMATORY Calvary Mausoleum		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. JUL 22 1954		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser 4228 S. Kingshighway Bl.			

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

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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 *Richard W. Storm*

Licensed Embalmer No. *400*

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.