

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25713**
Registrar's No. **1571**

FILED JUL 22 1954

BIRTH NO. _____ REG. DIST. NO. **517** PRIMARY REG. DIST. NO. **590**

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

1. PLACE OF DEATH a. COUNTY ST. LOUIS COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY ST. LOUIS	
b. CITY OR TOWN ROCK HILL		c. CITY OR TOWN Rock Hill 6310	
c. LENGTH OF STAY (in this place) FIVE YRS.		d. STREET ADDRESS (If rural, give location) 9803 Manchester Rd.	
d. FULL NAME OF HOSPITAL OR INSTITUTION ROCK HILL REST HOME			

3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) ELLA c. (Last) COMANN			4. DATE OF DEATH (Month) (Day) (Year) JUNE 28 1954		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH Dec. 1, 1870		9. AGE (In years last birthday) 83		10. IF UNDER 1 YEAR: Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY Home.		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY U.S.A.					

13a. FATHER'S NAME John T. Williams		13b. MOTHER'S MAIDEN NAME MARY B. ONEY		14. NAME OF HUSBAND OR WIFE MARTIN COMANN	
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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 MRS. MARIE COMANN, Richmond Heights, Mo	
				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) Chronic Myocarditis							
ANTECEDENT CAUSES		DUE TO (b) Senescent Arteriosclerosis					
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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"/>	
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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 <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 **11-14**, 19**49**, to **6-28**, 19**54**, that I last saw the deceased alive on **6-21**, 19**54**, and that death occurred at **4A** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) D. S. Werblin, M.D.		23b. ADDRESS 3107 Palomar		23c. DATE SIGNED 6-28-54	
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24b. DATE June 30, 1954		24c. NAME OF CEMETERY OR CREMATORY Linn Cemetery		24d. LOCATION (City, town, or county) (State) Wentzville, Missouri	
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DATE REC'D BY LOCAL OFFICE 6/29/54		REGISTRAR'S SIGNATURE Walter R. ...		25. FUNERAL DIRECTOR'S SIGNATURE Walter C. Rose, St. Charles, Mo.	
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H. C. Bane
620 Jefferson St.
St. Charles, Mo.

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

Clarence M. Bills

Licensed Embalmer No. *4375*

P. O. Address

St. Charles, Mo.

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