

FILED SEP 2 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 29107  
Registrar's No. 7303

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>7303</b>							
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____									
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (In this place) c. CITY OR TOWN <b>St. Louis,</b>		d. If 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 <b>St. Louis City Hospital #1</b>				e. STREET ADDRESS (If rural, give location) <b>21 1820 Market St.</b> <b>22190</b>									
3. NAME OF DECEASED (Type or Print) <b>IRENE</b>			a. (First)		b. (Middle) <b>MOLCHIN</b>		c. (Last)						
4. DATE OF DEATH <b>AUGUST 4, 1954</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Mar. 3, 1890</b>					
9. AGE (In years last birthday) <b>64</b>		IF CHECKED I YEAR Months Days		IF UNDER 1 YEAR Hours Mins.		11. BIRTHPLACE (City and State or Foreign Country) <b>Kansas City, Missouri.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>At Home.</b>			13a. FATHER'S NAME <b>James O'Donnell</b>			13b. MOTHER'S MAIDEN NAME <b>( UNKNOWN )</b>				
14. NAME OF HUSBAND OR WIFE <b>Carl Molchin</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No.</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Carl Molchin, 1820 Market St.</b>					
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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Meningitis</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Possible subdural hematoma</b>				19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION <b>Malnutrition</b>					
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>342.3</b>	
22. I hereby certify that I attended the deceased from <b>8-2</b> , 19 <b>54</b> , to <b>8-4</b> , 19 <b>54</b> , that I last saw the deceased alive on <b>8-4</b> , 19 <b>54</b> , and that death occurred at <b>11:15pm.</b> , from the causes and on the date stated above.													
23a. SIGNATURE <b>Joseph A. Egg M.D.</b>				(Degree or title)				23b. ADDRESS <b>1515 Lafayette</b>		23c. DATE SIGNED <b>8-5-54</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>8-5-54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>							
DATE REC'D BY LOCAL REG. <b>AUG 6 1954</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe 4700 Washington.</b>							

(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 *J. W. Dinkley*

Licensed Embalmer No. *3653*  
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.