

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. ....

0976

 BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

|   |   |   |  |  |   |                             |
|---|---|---|--|--|---|-----------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY |  |   |                             |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN <b>St. Louis, Mo.</b>  |   | c. LENGTH OF STAY (in this place)                                       | c. CITY OR TOWN <b>St. Louis</b>   |  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |                             |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Johns Hospital 6</b>   |   |   | e. STREET ADDRESS (If rural, give location) <b>5500 Itaska St.,</b>  |  |   |                             |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <b>Adele Marie</b> b. (Middle) <b>Paulette</b> c. (Last)   |   |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>1-31-55</b>  |  |   |                             |
| 5. SEX<br><b>female/</b>  | 6. COLOR OR RACE<br><b>white</b>  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>single</b> | 8. DATE OF BIRTH<br><b>June 7, 1885</b>  | 9. AGE (In years last birthday) <b>69</b>  | 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)<br><b>none at home</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY                                       | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>St. Louis, Mo. 0</b>  |  | 12. CITIZEN OF WHAT COUNTRY?  |                             |
| 13a. FATHER'S NAME<br><b>Leon B. Paulette</b>   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Abbie McGee</b>                         |  | 14. NAME OF HUSBAND OR WIFE<br><b>none</b> |   |                             |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>none none</b>   |   | 16. SOCIAL SECURITY NO.<br><b>none</b>                                  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><b>Leonore Paulette 5500 Itaska St.,</b>  |  |   |                             |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.                              | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Congestive Heart Failure</b><br>ANTECEDENT CAUSES <b>Kidney Failure</b><br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Coronaria of pancreas</b><br>DUE TO (c) <b>&amp; metastases to liver</b><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 1/2 hrs</b><br><b>3 wks</b><br><b>3 mos</b>                                      |                             |
| 19a. DATE OF OPERATION  | 19b. MAJOR FINDINGS OF OPERATION  |   |  |  | 20. AUTOPSY?<br>YES <input checked="" 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) m.  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21f. HOW DID INJURY OCCUR?<br><b>157 X</b>                              |  |  |   |                             |
| 22. I hereby certify that I attended the deceased from <b>Dec 1, 1954</b> , to <b>Jan. 31, 1955</b> , that I last saw the deceased alive on <b>Jan 1, 1955</b> , and that death occurred at <b>738 p.m.</b> , from the causes and on the date stated above. |   |   |  |  |   |                             |
| 23a. SIGNATURE (Degree or title)<br><b>[Signature] M.D.</b>   |   |   | 23b. ADDRESS<br><b>4957 Maryland St.</b>   |  | 23c. DATE SIGNED<br><b>2/1/55</b>   |                             |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>removal motor</b>   | 24b. DATE<br><b>2-3-55</b>  | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olive Cem.</b>             | 24d. LOCATION (City, town, or county) (State)<br><b>Lemay 23, Mo.</b>  |  |   |                             |
| DATE REC'D BY LOCAL REG.<br><b>FEB 2 1955</b>   | REGISTRAR'S SIGNATURE<br><b>[Signature] M.D.</b>  |   | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>Southern Funeral Home 6322 S. Grand Blvd., St. Louis, Mo.</b>                 |  |   |                             |

(Licensed Embalmer's Statement on Reverse Side)

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

FILED FEB 7 - 1955

DR S. H. PRANGE  
4952 MARYLAND  
FO. 1-3062

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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 *Francis J. Wyland Jr*  
Licensed Embalmer No. 457  
P. O. Address 4322 S. J.

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.