

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2965

FILED FEB 10 1955

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **0442**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	c. LENGTH OF STAY (in this place) 5 hr	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MAPLEWOOD 484	
d. FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN - HOSPITAL		d. STREET ADDRESS (If rural, give location) 7329 BRUNO AVE	

3. NAME OF DECEASED (Type or Print) a. (First) CAROLINE b. (Middle) B c. (Last) POURIE			4. DATE OF DEATH (Month) (Day) (Year) 1 13 55		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH Nov. 9th 1887	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months 2 Days 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) ST. LOUIS MO		12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME FRANZ - ORT		13b. MOTHER'S MAIDEN NAME CAROLINE WEDDE		14. NAME OF HUSBAND OR WIFE WM-DEWITT-POURIE	
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 ADDRESS DEWITT-POURIE - 7329 BRUNO -	

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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intestinal Obstruction due to Volvulus		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) Old adhesions		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Parkinson's Disease		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 5703

22. I hereby certify that I attended the deceased from **JAN-10th 1954** to **JAN 13th 1955**, that I last saw the deceased alive on **JAN 13th 1955**, and that death occurred at **10:50P.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Wm Dewitt Pourie / per W. J. Smith (M.D.)	23b. ADDRESS 3450 GRAVOIS - ST. LOUIS - MO	23c. DATE SIGNED 1-14-55
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 1-17-55	24c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEMETERY	24d. LOCATION (City, town, or county) (State) ST. LOUIS CO. MO
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DATE REC'D BY LOCAL REG. JAN 17 1955	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS JAY-B-SMITH - MAPLEWOOD - 17 - MO
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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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed *Stanley H. Ligon*

Licensed Embalmer No. *4693*

P. O. Address *St. L.*

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.