No. 300
10.48

FILED FEB 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3002

State File No. .....

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 0671

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

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1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
c. LENGTH OF STAY (in this place) 5 mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. LOUIS CITY HOSPITAL #1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo.
b. COUNTY
c. CITY OR TOWN St. Louis
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
STREET ADDRESS (If rural give location) 7408 Pennsylvania 2019 0

3. NAME OF DECEASED (Type or Print) a. (First) ALYCE b. (Middle) c. (Last) REMPP

4. DATE OF DEATH (Month) 1 (Day) 21 (Year) 55

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Apr. 4 1900
9. AGE (In years last birthday) 54 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) House Work
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo 0
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Thos O'Rourke
13b. MOTHER'S MAIDEN NAME Alice Walsh
14. NAME OF HUSBAND OR WIFE Jos.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME Gertrude Beckmann ADDRESS 7329 Michigan

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Nephrosathy & Acidosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diabetes Mellitus
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 260X

22. *I hereby certify that I attended the deceased from* 8-24, 1954, *to* 1-21, 1955, *that I last saw the deceased alive on* 1-21, 1955, *and that death occurred at* 4:40 P.m., *from the causes and on the date stated above.*

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23a. SIGNATURE W J Martin, M.D. (Degree or title)
23b. ADDRESS 1515 Lafayette Ave.
23c. DATE SIGNED 1/23/55

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE 1-25-54
24c. NAME OF CEMETERY OR CREMATORY Mt Olive
24d. LOCATION (City, town, or county) St Louis Co. (State) Mo

DATE REC'D BY LOCAL REG. JAN 24 1955
REGISTRAR'S SIGNATURE J. Earl Smith, M.D.
26. FUNERAL DIRECTOR'S SIGNATURE Jos. P. Fendler Jr. ADDRESS 7128 Michigan

S.P. (Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embal

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Clarence Jackson

Licensed Embalmer No. 309

P. O. Address 7158 Mer

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fai 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.