

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED APR 4 1955

BIRTH NO. _____ REG. DIST. NO. 717 PRIMARY REG. DIST. NO. 543 Registrar's No. 712

1. PLACE OF DEATH a. COUNTY St. Louis County		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) Jennings Mo		c. LENGTH OF STAY (In this place) 6 Months	
d. FULL NAME OF HOSPITAL OR INSTITUTION Halls Ferry Memorial Home		e. CITY OR TOWN St. Louis, Mo STREET ADDRESS (If rural, give location) 4572 Maffitt Ave	
3. NAME OF DECEASED a. (First) Agnes (Type or Print)		b. (Middle) _____ c. (Last) Weller	
4. DATE OF DEATH March 28, 1955 (Month) (Day) (Year)		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	
8. DATE OF BIRTH Nov 5, 1873		9. AGE (In years last birthday) 81 IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME George Fox		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Deceased		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME George D Weller ADDRESS 2858 Wyoming Ave	
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) Pulmonary edema ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Cardio-vascular disease DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic dementia	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) 4221	
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? _____		22. I hereby certify that I attended the deceased from July 23, 1954 , to March 28, 1955 , that I last saw the deceased alive on March 25, 1955 , and that death occurred at 12:30 AM , from the causes and on the date stated above.	
23a. SIGNATURE Lester Littmann (Degree or title) _____		23b. ADDRESS 8231 Clayton Rd	
23c. DATE SIGNED 3/28/55		24a. BURIAL, CREMATION, OR REMOVAL (Specify) REMOVAL	
24b. DATE Mar 30, 1955		24c. NAME OF CEMETERY OR CREMATORY Calvary Cem	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo		25. FUNERAL DIRECTOR'S SIGNATURE Sullivan ADDRESS 2849 No Euclid Ave	

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 *Albert Mayfield*.....

Licensed Embalmer No. *301*.....

P. O. Address *W. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.