

FILED MAY 13 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13320

1003

Registrar's No. 3731

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|---|--|--|--|--|--|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. _____ | | REGISTRAR'S NO. _____ | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____ | | | |
| b. CITY OR TOWN St. Louis | | c. LENGTH OF STAY (in this place) 4 days | | c. CITY OR TOWN St. Louis | | d. Is 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 Jewish Hospital | | | | e. STREET ADDRESS (If rural, give location) 815 Elias Avenue | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Pauline | | b. (Middle) _____ | | c. (Last) Foust | | 4. DATE OF DEATH (Month) (Day) (Year) April 26, 1955 | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married | | 8. DATE OF BIRTH April 8, 1928 | |
| 9. AGE (In years last birthday) 27 | | IF UNDER 1 YEAR (Months) _____ | | IF UNDER 2 HRS. (Hours) _____ | | IF UNDER 15 HRS. (Mins.) _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | | 10b. KIND OF BUSINESS OR INDUSTRY Homemaker | | | 11. BIRTHPLACE (City and State or Foreign Country) Neelyville, Missouri | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13a. FATHER'S NAME Roy Foust | | | 13b. MOTHER'S MAIDEN NAME Audrey Knight | | | 14. NAME OF HUSBAND OR WIFE Never Married | |
| 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. Unknown | | 17. INFORMANT'S SIGNATURE OR NAME Mr. Leo Foust, 815 Elias Avenue | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | MEDICAL CERTIFICATION | | | |
| | | | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute lymphatic leukemia | | | |
| | | | | INTERVAL BETWEEN ONSET AND DEATH: 7 weeks | | | |
| * This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. | | | | ANTECEDENT CAUSES | | | |
| | | | | Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. | | | |
| | | | | DUE TO (c) _____ | | | |
| | | | | II. OTHER SIGNIFICANT CONDITIONS | | | |
| | | | | Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary tuberculosis, FA-Oriented | | | |
| 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) _____ | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____ | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 2040A | | | |
| 22. I hereby certify that I attended the deceased from Oct. 23, 1953 , to April 26, 1955 , that I last saw the deceased alive on April 25, 1955 , and that death occurred at 6:30 a. m. , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE Ellis J. Lipsig, M.D. (Degree or title) | | | | 23b. ADDRESS 457 N. Kingshighway, St. Louis, Mo. | | 23c. DATE SIGNED 4/26/55 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE April 27, 1955 | | 24c. NAME OF CEMETERY OR CREMATORY Coon Island Cemetery | | 24d. LOCATION (City, town, or county) (State) Neelyville Missouri | |
| DATE REC'D BY LOCAL REG. APR 27 1955 | | REGISTRAR'S SIGNATURE J. Carl Smith | | VIA MOTOR Math. Hermann & Son Inc. 2161 E. Fair Ave., | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS | |
| (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.....
Glen W. Hay

Licensed Embalmer No. 37

P. O. Address.....
J. Kerin St.

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.