

FILED APR 27 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 13693  
2061

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St. Ferdinand TWP</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>				STREET ADDRESS (If rural, give location) <b>9860 Ventura Drive</b>			
3. NAME OF DECEASED (Type or Print) <b>CECILIA E MOHRE</b>			a. (First)	b. (Middle)	c. (Last)		
4. DATE OF DEATH <b>March 3rd, 1955</b>			(Month) (Day) (Year)				
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <b>married</b>		8. DATE OF BIRTH <b>January 9th 1885</b>		9. AGE (in years last birthday) <b>70</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>John Koder</b>		13b. MOTHER'S MAIDEN NAME <b>Sadie Sladson</b>		14. NAME OF HUSBAND OR WIFE <b>John Mohre</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME <b>John Mohre, 9860 Ventura Dr.</b>			
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Congestive Heart Failure</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Chronic Myocarditis &amp; Pericarditis</b> 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 <b>3 hrs.</b> <b>8 yrs.</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? 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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>4222</b>			
22. I hereby certify that I attended the deceased from <b>June 1953</b> to <b>March 3, 1955</b> , that I last saw the deceased alive on <b>Mar. 2, 1955</b> , and that death occurred at <b>4: A.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>N. J. Houck</b> (Degree or title) <b>MD</b>				23b. ADDRESS <b>8902 Riverview</b>		23c. DATE SIGNED <b>3-4-55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24b. DATE <b>3/7/55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>MAR 5 1955</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith - MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>DIEDRICH FUNERAL HOME, 8319 Hallsferry</b>			

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

JAN 11 1954

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 *W. W. Wilkins*

Licensed Embalmer No. *35*

P. O. Address *11 Lou*

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.