

FILED AUG 14 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25505

STATE FILE NUMBER

Registration District No. 312 Primary Registration District No. 547 Registrar's No. 1894

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Richmond Heights</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u> Length of stay in lb <u>30 min.</u>		d. STREET ADDRESS (If outside, give location) <u>1216 Bellevue</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LINDA</u> <i>First</i>		4. DATE OF DEATH <u>August 5, 1956</u> <i>Month Day Year</i>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>April 11, 1904</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Manager</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Le Chateau Restaurant</u>	9c. AGE (In years last birthday) <u>52</u>
10a. BIRTHPLACE (City and state or country) <u>Weatherby, Mo.</u>		10b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. FATHER'S NAME <u>E. L. Marden</u>		12. MOTHER'S MAIDEN NAME <u>Edna Werland</u>	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		14. SOCIAL SECURITY NO. <u>498-20-7025</u>	
15. INFORMANT <u>George R. Karros, 10405 Clayton Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> DUE TO (b) <u>Hypertensive Encephalopathy</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			<u>334X</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____		
20c. TIME OF INJURY: Hour _____ a. m. _____ p. m. Month _____ Day _____ Year _____	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		
20e. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____	20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____		
21. I attended the deceased from <u>Aug 5</u> to <u>Aug 5</u> and last saw her alive on <u>Aug 5</u> . Death occurred at <u>7:45 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Neal W. B. Bawee MD.</u>		22b. ADDRESS <u>4660 Maryland</u>	
22c. DATE SIGNED <u>8/6/56</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug. 8, 1956</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>
24. FUNERAL DIRECTOR <u>Alexander & Sons 6125 Belmont</u> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>8-7-56</u>	26. REGISTRAR'S SIGNATURE <u>Herbert R. Donle MD</u>

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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21.

Dr. Bawell
4660 Maryland

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..... *Jos. E. McCulloch*

Licensed Embalmer No. *276*

P. O. Address *6179 Del...*

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