

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28126
6523

FILED SEP 7 1956

State File No. 28126
Registrar's No. 6523

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 28126		Registrar's No. 6523	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) ---a. STATE Missouri b. COUNTY St. Louis					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis				c. LENGTH OF STAY (in this place) 1 day		c. CITY OR TOWN Pine Lawn		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital				e. STREET ADDRESS (If rural, give location) 3704 Manola Avenue					
3. NAME OF DECEASED (Type or Print) a. (First) Janette C. b. (Middle) _____ c. (Last) Birckhead				4. DATE OF DEATH (Month) (Day) (Year) 7 - 10 - 1956					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 7 - 4 - 1921		9. AGE (In years last birthday) 35	
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, Missouri				12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME B. H. Mohr			13b. MOTHER'S MAIDEN NAME Ether Mongan			14. NAME OF HUSBAND OR WIFE Roy Birckhead			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. Roy Birckhead, 3704 Manola 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, assthenia, etc. It means the disease, injury, or complication which caused death.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intra cerebral hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Congenital aneurysm of left anterior cerebral artery II. OTHER SIGNIFICANT CONDITIONS zone Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH 20 hrs	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 754.6						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) m. _____		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 _____, 19 <u>45</u> , to <u>July 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 10</u> , 19 <u>56</u> , and that death occurred at <u>11:30 P.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Dr. C. N. Pridemore M.D.				23b. ADDRESS 4126 Shren Ave				23c. DATE SIGNED 7/12/56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Buried		24b. DATE 7/13/56		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri			
DATE REC'D BY LOCAL REG. JUL 12 1956		REGISTRAR'S SIGNATURE J. Carl Smith M.D.				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Drehmann-Harral 1905 Union Blvd.			

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

Dr. Carl H. Lindeman
4126a Shreve Ave. Thur. 10:30 - 2
No. Wed.

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 R. Thompson*

Licensed Embalmer No. *431*

P. O. Address *H. J. ...*

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.